The Alabama Department of Mental Health's

Division of Developmental Disabilities (DDD) Provider Operational Guideline Manual

Serve · Empower · Support

Promoting the health and well-being of Alabamians with mental illness, developmental disabilities and substance use disorders.

DDD implements the Mission and Vision of the Alabama Department of Mental Health by assuring that people with Developmental Disabilities are provided quality supports and services to lead meaningful lives through their choice of employment, home and relationships.

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The Alabama Department of Mental Health

Division of Developmental Disabilities

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Operational Guidelines Manual

Table of Contents

SUMMARY OF CHANGES TABLE

Operational Guideline #	Operational Guideline Title	Action Taken
1.2.a.	Criteria for Determining Eligibility and placement on the Waiting List	Revised
1.2.d.	Wait List Selection Process	Revised
1.6.d.	Waiver Admission Process	Revised
4.2.	Request for Action/Services	Revised
4.8	Support Coordination Guideline	Revised
5.10	Direct Service Provider Operational Requirements	New
5.2.a.	Certification Status and Adding New Settings, Services, and/or Individuals	Revised
6.1.	Certification Process Review Process	Revised
6.2.	Provider Training and Technical Assistance	Revised
6.3.b.	Promotion and Protection of Individual Rights	Revised
6.3.c.	Dignity and Respect	Revised
6.3.d.	Natural Support Networks	Revised
6.3.e.	Protection from Abuse, Neglect, Mistreatment, and Exploitation	Revised
6.3.f.	Best Possible Health	Revised
6.3.g.	Safe Environments	Revised
6.3.h.	Staff Resources and Supports	Revised
6.3.i.	Positive Services and Supports	Revised
6.3.j.	Continuity and Personal Security	Revised
6.3.k.	Quality Improvement System	Revised
6.3.l.	Personal Care, Companion, Respite and Crisis Intervention Services, and Supported Employment at an Integrated Worksite	Revised
7.1.a.	Behavior Support Plan Writing and Content	New
8.1.c.	IRBI Completion and Workflow	Revised
8.3.c.	Assistive Technology & Virtual Service Guidance via Appendix K/PHE2020	Revised
8.5.	Memorandum of Agreements (MOA) for non-contracted HCBS Waiver Services	Revised

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Letter from Associate Commissioner

May 31, 2021

Thank you for your participation in the Alabama Department of Mental Health's Division of Developmental Disabilities (ADMH-DDD), serving individuals with intellectual and developmental disabilities. The development of a service delivery system that is responsive to the needs of people with disabilities is a priority for the ADMH- DDD. Therefore, this version of the ADMH-DDD provider manual represents the Division's commitment to provide a statewide system, of services and supports, that is efficient and effective.

Alabama Administrative Code regulation 580-5-29.01 sets forth our Division's authority and responsibility to establish reasonable rules, policies, orders and regulations that provide details of carrying out its duties and responsibilities. It is important to note this manual is the ADMH-DDD's effort to document policies, practices and procedures that were indicated a priority by internal staff to improve on certain practices and to ensure facilitation of the same are in alignment with expectations set forth in this manual across all regions. Although some of the guidelines may directly relate to direct service providers, the manual does not encompass all provider requirements. As the ADMH-DDD embarks on further improving person centered practices and individual choice of those served, this manual will continue to evolve and be updated to reflect progress towards those efforts.

ADMH-DDD perceives providers and all stakeholders as partners in a common goal to provide quality, person- centered, and cost-effective services, to individuals with intellectual and developmental disabilities so they may live fulfilling and rewarding lives. We look forward to future work around guidelines that include stakeholder engagement and evaluation of the ADMH-DDD service delivery system.

Sincerely,

Terry L. Pezent
Associate Commissioner, ADMH-DDD

CHAPTER 1
ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

1.1. Intake/Information and Referral

Responsible Office: Support Coordination/Call Center
Reference: Settlement Agreement in Susan J., et al, v Bob Riley, et al; Case Management Standard Operational Procedures (SOP), Medicaid Waiver, Administrative Code Chapter 580-5-30
Effective: October 1, 2020
Statement: The Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DD) designated a statewide 1-800 Call Center (CC) as the initial point of contact to request Home and Community Based Services (HCBS) as a part of the settlement in the Susan J. vs. the State of Alabama and ADMH-DD.
Purpose/Intent: The CC is the centralized point of contact to initiate and ensure the request of referrals will be expedited. The CC handles hundreds of calls each month from people all over the state as well as across the country seeking information and services. Through a series of questions, the CC staff records each caller's request and determines whether the application process should be initiated or if the caller should be directed to another human service agency. For persons who have an intellectual disability, demographic information is taken and referred to the designated Intellectual Disabilities (ID) Support Coordination Agency covering the county of residence of the person in need of service. CC staff discloses and explains the requirements of the waiver programs. The intake information is maintained by a CC staff person for follow-up to ensure timely contact by the Support Coordination Agency (SCA). To access ADMH-DD administered waiver services, all request must come to the CC. Regardless of the location of the caller, the county in which the legal guardian or the person resides will dictate the regional office and support coordination agency (SCA) to which the referral will be sent.
Scope: Support Coordination Services; ADMH-DDD Central/Regional Offices
Definitions: Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DD); Call Center (CC); Home and Community Based Services (HCBS), Support Coordination Agency (SCA)- formerly referred to as Case Management Agency, Support Coordinator (SC)- formerly referred to as case manager, Division of Developmental Disabilities Information Management System (DDD IMS)
Procedures:
Those seeking services for person with intellectual disabilities through the Alabama Department of Mental Health Division of Developmental Disabilities should:

1. Contact the Division of Developmental Disabilities Call Center at 1-800-361-4491.
2. The Call Center staff will complete the initial contact application on referrals for individual's three (3) years of age and up who meet the eligibility requirements and will request the Intellectual Quotient (IQ)(69 and below) of the person in need of services in addition to other pertinent information.
3. CC staff will accept calls from the individual requesting services, the legal guardian, the primary caregiver, or other interested parties who have consent to relay information and who will be responsible with assisting with the referral process.

4. Within two business days, an initial contact form will be sent via a note in DDD IMS to the local designated support coordination agency or other designated point of entry.
5. CC staff will make referrals to the SCA based solely on verbal report of the caller. CC staff will not deny application for wait list to any caller.
6. If the caller states they do not have an intellectual disability, the CC will process the application and refer to other applicable state or community services.
7. When there is more than one support coordination provider in the county, the individual will be provided choice of provider.
8. The designated support coordination agency for each county/area serves as the point of entry for waiver applications. The designated support coordination agency collects necessary documentation and files the application with the Regional Community Service Office. The Regional Community Service Office processes all complete waiver applications to either determine an individual ineligible for the waiver or eligible but placed on a waiting list. Subsequent enrollment in one of the waivers depends on criticality of need, availability of resources, and space within the waiver caps on the number who can be served.
9. The Initial Contact Information Form will be sent to the SCA via the DDD IMS notes. This form will have the type of referral checked in the box at the top. There are three options; the first is the Initial Application Referral which reflects a first-time applicant requesting services. The second is Referral for Update which means there has been a call received from/for someone who already has been referred to the SCA but a Notice of Incomplete Application was sent to the requester. Third is the Info/Referral only which is used for persons looking for services outside of ADMH-DD. The same information sent to SCA is sent to the ADMH-DD Regional Office Wait List Coordinator. The eligibility determination process continues to be the prerequisite for all categories.
10. CC staff will send a letter to the person calling, verifying the date of call and that their requests have been forwarded to the designated SCA in their area to continue the application process.
11. CC staff will open a DDD IMS enrollment for the person in need of service. It is the responsibility of the SCA to make a change in DDD IMS reflective of the assigned support coordinator from the CC.
12. CC staff will send the application for services on referrals made by Department of Human Resources (DHR) on children or adults in their custody to the DHR, ADMH-DD contact, to the support coordination agency, to the Regional Community Service Director and the Community Service Waitlist Coordinator.
13. Once the application is received by the SCA from the ADMH-DD CC, the intake person should contact the individual or their representative immediately; but no later than 5 business days.
14. If by 30 days after the referral has been received from the Call Center and the SCA has not contacted the person or the documents have not been provided by the caller and/or sent to the regional office, then the CC will contact the SCA. This ensures the SCA has made attempts to contact the person requesting services. The SCA must document their efforts to contact the person or their family in DDD IMS notes. Reasonable efforts to contact the person or family member would be two documented phone calls and a letter.
15. If by 60 days after the referral has been received from the CC and contact has not been made or documents have not been gathered, then an email will be sent by the call center coordinator to the SCA intake person and the waitlist coordinator requesting a follow-up.

16. The SCA must document their efforts to contact the person or their family in the DDD IMS notes. Reasonable efforts to contact the person or family member would be two documented phone calls and a letter.
17. Once contact with the individual seeking services has been established, the SCA will submit the completed information packet for review to the Regional Community Service Office that serves the applicant's county and, if approved, the applicant's name will be placed on the waiting list. ADMH will make a decision of eligibility within 30 days of the receipt of the completed application.

******Exceptional Circumstances: If an individual or their family member has difficulty with communication via the phone, arrangements can be made with the Regional Community Service Office to set up a face-to- face meeting.***

******Exceptional Circumstances: When a military family calls the CC to request services in Alabama, the family will need to email, fax or mail their relocation documents to staff within 30 thirty days of their move.***

1.2. Waiting List

1.2.a. Criteria for Determining Eligibility and Placement on the Waiting List

Responsible Office: Regional Community Services

Reference: Administrative Code 580-5-30-.14, Eligibility and Level of Care Determinations for Medicaid Waiver Programs

Revised: March 26, 2021

Statement: Eligibility for Waiver services and placement on the Waiting List will be determined based on verifiable and valid documentation.

Purpose/Intent: The process for determining eligibility for Waiver services and being placed on the Waiting List involves specific, crucial steps governed by detailed standards and practices of communication between the Waiting List Coordinator and the Support Coordination agency.

Scope: Director of Community Programs; Regional Community Services; Support Coordinators

Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); ICAP (Inventory for Client and Agency Planning)

Procedures:

1. The Waiting List Coordinator reviews eligibility documentation in the application packet provided via web- based application by the designated Support Coordination agency, which must include:
    a. A qualifying psychological evaluation administered/interpreted by a qualified professional on/after the eighteenth birthday (for an adult) or within three years of the date of application (for a child less than eighteen years of age).
    b. For a person eighteen years of age or older, another qualifying psychological evaluation prior to the eighteenth birthday.
    c. An ICAP Compuscore report completed within ninety days of the date of a complete application packet.

2. In order for the applicant to be deemed eligible for Waiver services and, thus, placement on the Waiting List, the submitted eligibility documents must unequivocally demonstrate the following:
    a. The applicant evidences significant problems in at least three adaptive functioning subscales (Self-Care, Receptive & Expressive Language, Mobility, Self-Direction, and Capacity for Independent Living and Learning), determined as follows:
        - Self-Care: ICAP Personal Living Domain score < 509 for persons aged 17 or older (reduced cut-off score for younger persons), or (for ages > 4) ICAP Arm/Hand Use item includes 'Some daily activities limited' or 'Most daily activities limited'.
        - Receptive & Expressive Language: ICAP Social/Communication Domain score < 515 for persons aged 17 or older (reduced cut-off score for younger persons), or (for ages > 4) ICAP Communication item includes 'None' or 'Gestures' or 'Sign language or finger spelling' or 'Communication board or device'.
        - Mobility: As determined by responses selected for items 9a and 9b of the Eligibility Assessment, with regard to ability to walk independently and any assistance/assistive devices needed.
        - Self-Direction: ICAP Community Living Domain score < 514 for persons aged 17 or older (reduced cut-off score for younger persons), or ICAP General

Maladaptive Behavior includes 'Marginal Problems', 'Moderate Problems' or 'Very Serious Problems'.

- Capacity for Independent Living: ICAP Broad Independence Domain score < 510 for persons aged 17 or older (reduced cut-off score for younger persons).
- Learning: As determined from the Diagnosis Record.

b. The applicant achieved a full-scale IQ score below 70, with no evaluations documenting a full-scale IQ score of 70 or above on an accepted intellectual assessment. The highest score of any evaluation administered will be the score considered as valid.
c. Onset of the applicant's intellectual disability occurred before the age of eighteen.
d. The primary cause(s) of impaired functioning or the full-scale IQ less than 70 is not the result of mental illness or external factors such as medication or stress.

3. In the event the application packet does not include any of the documentation listed in 1., above, or does not unequivocally demonstrate that the person meets the eligibility criteria listed in 2., above, the application packet will be considered incomplete, and the Waiting List Coordinator will communicate via DDD IMS to the Support Coordination agency details on which document(s) and/or information (if any) are needed to complete the packet and make a determination on eligibility.
    a. In the event the needed document(s) and/or information are not submitted within 60 days of the Waiting List Coordinator's DDD IMS notification, the application packet will be deemed incomplete, and the Waiting List Coordinator will send to the applicant a Notice of Incomplete Application (found in the Enrollments record in the DDD IMS). A copy of this notification will be recorded in the DDD IMS.
    b. If the applicant has conflicting documentation or has an IQ of over 65 or is hospitalized at the time of application or presents with multiple diagnosis. The CSD will request that the application be reviewed by the Behavioral and Psychological Evaluators from at least three Regional Offices, who will provide a written summary of their recommendation of eligibility within 45 days of receipt of request for review.
4. The Waiting List Coordinator reviews the eligibility question in the Alabama Wait List Application Report in the DDD IMS record.
    a. If the answer to the pertinent eligibility question is "Yes", the Waiting List Coordinator will proceed, as outlined in 6., below.
    b. If the answer to the pertinent eligibility question is "No", the Waiting List Coordinator will review the Eligibility Assessment and the Diagnosis Record to determine data needed to support eligibility and will request any necessary substantiating documentation from the Support Coordinator via the DDD IMS.
    c. The Waiting List Coordinator will only designate the Wait List record as "Approved" when the response to the pertinent eligibility question is substantiated by data on-hand to be "Yes".
5. In the event the applicant is deemed ineligible for Waiver services, the Waiting List Coordinator will send to the applicant a Wait List Denial Notification (found in the Enrollments record in the web-based application), which includes full details on appeal rights and processes. A copy of this notification will be recorded in the DDD IMS.

6. When all necessary documents are received and contain the required eligibility information, and within ninety days of the date of a complete application packet, the Waiting List Coordinator reviews the criticality assessment, completed by the Service Coordination agency to ensure:
    a. All fields are completed fully and accurately.
    b. Each service group is selected under only one needs Category.
    c. Substantiating documentation is provided via DDD IMS, if Category 1 (High Risk) is selected for any service group.
7. Once eligibility is positively determined, and the criticality assessment is reviewed and completed, the Waiver Coordinator will designate the person's Wait List record in the DDD IMS as Approved, thus placing them on the Waiting List.
8. Upon approval for the Waiting List, the Waiting List Coordinator will send to the applicant an Initial Eligibility Notification Letter. A copy of this notification will be recorded in the DDD IMS.

1.2.b. Wait List Eligibility Applications from ADMH Inpatient Facilities

Responsible Office: Office of Community Programs, Call Center
Reference: ADMH Administrative Code 580-5-30-.13, Alabama Medicaid Code, Call Center Procedures
Statement: The Alabama Medicaid Agency designates the DMH as the entity authorized to determine individuals' eligibility for participation in the Medicaid Home and Community-Based Services (HCBS) Waiver for persons with Intellectual Disabilities (ID Waiver) and for the Alabama Living at Home Waiver (LAH Waiver). Within the DMH, the oversight and monitoring of day to day operations of the Waiver programs are conducted by the Division of Developmental Disabilities through its Central Office and its Regional Community Service Offices.
Purpose/Intent: To centralize the process of wait list eligibility for ADMH inpatient applicants utilizing the DD Call
Center and Regional Community Services Offices as main points of contact to improve efficiency and uniformity in eligibility determinations, statewide.
Scope: These procedures apply to ADMH facility staff, Regional Community Services Offices, and ADMH-DD Call Center.
Definitions: ADMH Inpatient Facilities- Bryce Hospital, Mary Stark Harper Center, Taylor Hardin Secure Medical
Facility (THSMF) DDD IMS – Division of Developmental Disabilities Information Management System. This system has previously been known as MRSIS.
Procedures:

1. Patient representative (typically ADMH social worker) initiates call to ADMH-DD Call Center to begin wait list application process for patient currently hospitalized.
2. Intake application information is gathered and entered into DDD IMS by call center staff.
3. Patient representative is routed to appropriate Community Services Office with regard to the patient's region of origin.
4. Application is sent to patient's region of origin Community Services Director and Wait List Coordinator.
5. Patient representative is instructed to submit supporting documents and all other application materials to the Community Services office. All communications needed for completion of application will be facilitated from Regional office to ADMH patient representative.

6. Eligibility determination is rendered by the Regional Community Services Office and standard process of notification is followed.
7. ADMH facilities will adhere to same process for appeals as community applicants.

1.2.c. Waiting List – Entry to Services

Responsible Office: Regional Community Services
Reference: 1915c Home and Community Based Intellectual Disabilities Waivers; Wait List Selection Process, O.G 6.5; Administrative Code 580-5-30-.13
Revised: December 28, 2020
Statement: Persons on the Waiting List are periodically identified to enter Waiver services.
Purpose/Intent: Entry to Waiver services requires communication between Regional Community Services and Support Coordinators and between Support Coordinators, applicants, and potential providers, as well as verification of eligibility.
Scope: Director of Community Programs; Regional Community Services; Support Coordinators; DDD Central Office
Definitions: RCS (Regional Community Services); MSIQ (Medicaid Database); ICAP (Inventory for Client and Agency Planning); Request for Proposal (RFP); ID (Intellectual Disabilities); LAH (Living at Home)
Procedures:

1. DDD Central Office notifies RCS of those applicants on the Waiting List identified for entry to Waiver services.
2. The Waiting List Coordinator:
    a. Identifies those applicants specific to their Region approved for Waiver services.
    b. Sets the Waiting List status of each approved applicant to "Pending" in the web-based application.
    c. Verifies the Medicaid eligibility for the ID or LAH Waiver of each approved applicant via MSIQ.
    d. Reviews the Waiver eligibility information submitted at the time of application and, if necessary, requests updated information (including an ICAP score within 60 days) to verify current eligibility.
    e. Notifies the responsible Support Coordination agency(s), via the web-based application, of each applicant approved for Waiver services, provides the verified Medicaid eligibility information for each, and directs them to serve the identified person(s).
    f. Adds to the Placement Committee agenda each applicant approved for the Waiver and:
        i. Reviews documentation in the web-based application and communicates with the Support Coordinator at least biweekly to track and report progress toward entry to Waiver services.
        ii. Collaborates with the Support Coordinator to troubleshoot and resolve any barriers to entry to Waiver services (e.g., Medicaid ineligibility, inaccurate contact information, non-response to RFP(s)).
        iii. In the event of non-response to RFP's, forwards to other applicable Regional Offices (CSD or designee) the RFP(s) prepared by the Support Coordinator for each applicant identified for entry to Waiver services, allowing 7 business days for providers to respond.

3. The Support Coordinator circulates the RFP(s) for each applicant identified for entry to Waiver services, allowing 7 business days for providers to respond.
4. In the event the Support Coordinator exhausts all available contact options and is unable to make contact with the approved applicant or their caregiver(s) within 10 working days of the first attempt at contact, the Support Coordinator will send to the most recent residential address on record a certified letter requesting immediate response. If there is no response to the certified letter within an additional 10 working days, the applicant's Waiting List Record will be denoted as "Services Not Needed/Wanted" in each service category (e.g., Residential, Day and Supports). The applicant will remain on the Waiting List with their record closed to Support Coordination in the web-based application.
5. After initial contact with the approved applicant or their caregiver, the Support Coordinator identifies needed Waiver services and initiates the process of choosing providers, preparing and transmitting to the Waiting List Coordinator the RFP, as noted in 2f, above. If the applicant or caregiver does not choose among responding providers within 90 days of this initial contact, the applicant's Waiting List Record will be denoted as "Services Not Needed/Wanted" in each service category (e.g., Residential, Day and Supports). RCS will notify the applicant of this action by letter.

1.2.d. Wait List Selection Process

Responsible Office: System Management
Reference: ADMH Administrative Code 580-5-30-.14, 6.2.a. Criteria for Determining Eligibility and Placement on the Waiting List, 1.2.c. Waiting List - Entry to Services
Revised: May 28, 2021
Statement: A list of names will be selected periodically
Purpose/Intent: To ensure eligible individuals waiting for services are admitted periodically at time frames determined by the ADMH Central Office
Scope: ADMH-DDD Central/Regional Offices; HCBS: ID, LAH, CWP
Definitions: Central Office (CO); Mental Health (MH); Regional Office (RO)
Procedures: Upon notification to the CO MH Specialist II responsible for the submissions of applications to Alabama Medicaid Agency, the CO MH Specialist II will select the number of individuals for the wait list as instructed by the CO Director of System Management by:

1. Running the report through the following process:
    a. At the System Home Screen choose the **ID Wait List**
    b. At ***Filters*** select work queue that is equal to "**Approved**"
    c. Select ***Rank*** as the number instructed by the Director of System Management
    d. Select ***Status*** equal to "**Waiting, no services being provided**"
    e. Click ***Search*** and the report will be extracted
    f. Click on "**Alabama ID wait list ranking**" in blue print at the top of the page
    g. Export the data in desired program format
2. Save and Print the report.
3. Send the wait list to all the RO Community Services Directors who will notify the RO Wait List Coordinator.

4. The RO Wait List Coordinator verifies each individual's eligibility, as evidenced by a "Yes" answer to the applicable eligibility question (1915c waiver or 1915i waiver) within the Alabama Wait List Application Report in the individual's DD Information System record and verifies each individual's Medicaid eligibility status. [Refer to 1.2.a]
5. The RO Wait List Coordinator enters a note in the DD Information System that alerts the Support Coordinator as to action(s), if any, needed to begin the initial application process. [Refer to 1.2.c]
6. The RO Wait List Coordinator will notify the appropriate Support Coordination Agency to begin the initial application process for those individuals identified for initial admission to the waiver.
7. The RO Wait List Coordinator will put the individual's case in "pending" status, in the DD Information System, to ensure the individual's name is not duplicated on the next wait list selection.
8. The CO MH Specialist II will monitor the initial applications and mark through the names of the individuals processed indicating the application was processed through the Alabama Medicaid Agency's Long-Term Care software.
9. The CO MH Specialist II will contact the RO Wait List Coordinator periodically to determine the status of those applications not processed.
10. The CO MH Specialist II will report to the CO Director of Systems Management the number of individuals selected for each period and updates on the number of individuals whose applications have not been processed.

1.2.e. Interregional Medicaid Waiver Transfers

Responsible Office: Regional Community Services
Reference: Request for Interregional Medicaid Waiver Transfer Form
Effective Date: Historical Practice
Statement: Persons receiving Medicaid Waiver services relocate their homes in new areas of the state, requiring transfer of responsibility to new RCS and Support Coordination offices and of services to new providers.
Purpose/Intent: When persons receiving Medicaid Waiver services relocate to a new physical address lying in a different Region, effective communication of services, needs, and plans must occur between the RCS staff and Support Coordination staff in both sending and receiving Regions.
Scope: Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions: Alabama Department of Mental Health (ADMH); Division of Developmental Disabilities (DDD); Regional Community Services (RCS); Person-Centered Plan (PCP); Community Services Director (CSD)
Procedures:

1. In the event that a person receiving Medicaid Waiver services notifies the Support Coordinator that they intend to relocate to another area of Alabama lying in a different Region, as defined by ADMH DDD, the Support Coordinator will initiate the Request for Interregional Medicaid Waiver Transfer Form.
2. The Request for Interregional Medicaid Waiver Transfer Form will be signed by acting agencies and then forwarded, via the web-based application, to the next at each corresponding step in the process, outlined as follows.

3. The sending support coordination agency informs the sending CSD of:
    a. The person's/family's request for transfer to another Region (via written verification)
    b. Region to which the transfer will occur
    c. Availability of any matching funds
    d. Services the person is currently receiving and will need upon transfer
    e. Any other supports needed/requested.
4. The sending CSD notifies the receiving CSD of the request for transfer/services.
5. The receiving CSD determines if the needed/requested services are available in the receiving Region and informs the sending CSD of the results of that determination.
6. The sending CSD notifies the sending support coordination agency whether to proceed with the transfer or, if the needed/requested services are unavailable in the receiving Region, to meet with the person/family for additional planning.
7. If the transfer proceeds:
    a. The sending support coordination agency:
        i. Notifies, in writing, all current providers listed on the Plan of Care and documents the date of notification on the Interregional Medicaid Waiver Transfer Form.
        ii. Conducts a discharge meeting.
        iii. Provides a Request for Proposal (RFP) to the receiving Placement Coordinator, to be distributed to Support Coordination Agencies in the receiving Region.
    b. The receiving CSD notifies the receiving support coordination agency to:
        i. Coordinate with the sending support coordination agency to exchange all necessary documentation (e.g., releases of information, assessments, Plans of Care, etc.).
        ii. Establish timeframes for choice visits and a projected date of transfer.
        iii. Sign and return the Interregional Medicaid Waiver Transfer Form, including the date receiving providers were notified of the transfer.

8. The receiving CSD forwards a copy of the Interregional Medicaid Waiver Transfer Form to the sending CSD for distribution.
9. Upon receipt of all documentation, including (but not limited to) waiver documentation, support coordination documents, PCP, etc., the transfer will be initiated.

1.3. Inventory for Client and Agency Planning (ICAP) for Community Services

Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30.14 Eligibility and Level of Care Determinations for Medicaid Waiver Programs
Statement: The ICAP is administered by the Support Coordinator to assess adaptive eligibility for the Waiver.
Purpose/Intent: Adaptive eligibility for Waiver services must be established upon application for the Waiver and
annually at the point of re-determination.
Scope: Director of Community Programs, Regional Community Services; Support Coordinators; DDD Central Office
Definitions: ICAP (Inventory for Client and Agency Planning); RCS (Regional Community Services); CSS (Comprehensive Support Services)
Procedures:

1. Prior to administering the ICAP, the Support Coordinator will be trained in its administration by the RCS Behavioral and Psychological Evaluator or, in the absence of that position, a member of the CSS Team.
2. The Support Coordinator administers the ICAP:
    a. Upon referral from ADMH of an applicant for the Waiver, the ICAP administration must occur within 90 days of the application being submitted to the RCS office for eligibility determination.
    b. At least every two (2) years at the point of re-determination of eligibility.
    c. Anytime information regarding the person served changes significantly.
3. In completing the ICAP, the administering Support Coordinator is to interview the applicant/person served and/or a caregiver most familiar with the capabilities of the person served (e.g., someone who has close, daily involvement), as indicated. The ICAP protocol is not to be given to a provider or provider employee/staff person to complete on their own.
4. The applicable scores yielded by the ICAP administration are entered into the Eligibility Assessment in the web- based application.
5. For reference, the completed ICAP protocol is scanned and uploaded to the record of the applicant/person served in the web-based application.

1.4. Criticality Assessment

Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30
Statement: The Criticality Assessment is completed by the Support Coordinator and then electronically submitted, via DDD IMS, for approval by Regional Community Services.
Purpose/Intent: The Criticality Assessment was created by the Department of Mental Health to evaluate the urgency of a person's need for services.
Scope: Director of Community Programs; Regional Community Services; Support Coordination
Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); CSD (Community Services Director)
Procedures:

1. The Support Coordinator completes/updates the Criticality Assessment using verifiable information obtained from pertinent documentation and/or interviews with the person applying for Waiver services and/or their caregiver(s).
    a. Specific substantiating documentation must be obtained and uploaded to DDD IMS Notes if Residential and/or Supports services are selected in Category 1 – High Risk.
2. The Criticality Assessment is to be completed by the Support Coordinator within 90 days prior to the application for Waiver services.
3. The Criticality Assessment is to be updated by the Support Coordinator within three (3) business days anytime they are informed the person on the Waiting List has experienced a substantial change in circumstances and/or needs.
    a. When the Criticality Assessment is denoted as Complete by the Support Coordination supervisor, the Support Coordinator notifies the Waiting List Coordinator of the updated Criticality via DDD IMS Notes.
4. Upon notification of a New or Updated Criticality Assessment, the Waiting List Coordinator reviews it within three (3) business days and resolves it by denoting it as Approved or by notifying the Support Coordinator, via DDD IMS Notes, of needed corrections or documentation.
5. The Waiting List Coordinator checks the Waiting List tab in DDD IMS weekly for New and Updated Criticality Assessments and resolves each by denoting them as Approved or by notifying the Support Coordinator, via DDD IMS Notes, of needed corrections or documentation.
6. Anytime the Waiting List Coordinator denotes a Criticality Assessment as Approved, they are to immediately set the Wait List Work Queue to Approved, thus ranking the person on the Waiting List according to the new/updated Criticality score.

1.5. Request for Psychological Testing

Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30-.14 Eligibility and Level of Care Determinations for Medicaid Waiver Programs
Statement: The Alabama Medicaid Agency designates the DMH as the entity authorized to determine individuals' eligibility for participation in the Medicaid Home and Community-based (HCBS) Waiver for persons with Intellectual Disabilities (ID Waiver) and for the Alabama Living at Home Waiver (LAH Waiver)
Purpose/Intent: Assist persons who are seeking placement on the Alabama Department of Mental Health Division of Developmental Disabilities Waiver Waiting List with obtaining Psychological Testing to establish eligibility for ID and LAH Waiver services.
Scope: Director of Community Programs; Regional Community Services; Support Coordinators
Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); RFA (Request for Action); ICAP (Inventory for Client and Agency Planning); CSD (Community Services Director); IEP (Individualized Educational Plan); CSS (Comprehensive Support Services); BPE (Behavioral & Psychological Evaluator)
Procedures:

1. The following should be completed, and documentation should be uploaded into DDD IMS by the support coordination agency prior to requesting intelligence testing from the Regional Office:
    a. Collect educational information such as most recent IEP or other school related records.
    b. Collect all prior psychological testing results and/or reports.
    c. If, upon review of the eligibility information submitted, further psychological testing is required to accurately determine eligibility for the Waiting List, all community options for psychological testing must be exhausted.
        - Community options may include, as applicable, school psychometrists, licensed private practitioners, Rehabilitative Services, etc.
    d. Administer ICAP. Note that, if no intellectual testing results are available prior to age 18, the ICAP may still be administered.
    e. Collect all relevant and adequate developmental documentation.
2. If no community options for psychological testing are accessible, it is appropriate to request testing from the Regional Office, and the support coordination agency should:
    a. Submit the Regional Request for Action Form (RFA) to the designated Regional Office. At minimum, the RFA should include:
        - Information concerning prior testing results (either submit in DDD IMS or include in supporting documentation with RFA).
        - A brief explanation as to what community resources were attempted, and the barriers to having the testing completed within the community.
3. When appropriate, the RFA team will approve the RFA and the following steps should be taken:
    a. The CSD will assign either the Behavioral & Psychological Evaluator (BPE), or consult with the Director of Psychological Services to assign a member of a CSS team, to administer the intelligence test.

b. The assigned tester will contact the support coordination agency to schedule a testing date, secure an area for testing with the support coordination agency, and gain any additional information regarding the individual who will be tested.
c. The assigned tester will enter test results in DDD IMS and upload psychological report within 10 business days of the test administration. The original psychological report will be filed in the office of the BPE in Regional Community Services.

1.6. Waiver Services

1.6.a. Wait List for Services to Children

Responsible Office: Regional Office

Reference: ADMH Administrative Code 580-5-30; Pursuant to the current DMH/DD policy of the DD Call Center, referrals are accepted on individuals ages 3 and above.

Statement: Referrals of children ages 3 – 21 to DMH/ID/DD are for alternative residential services and / or specialized educational services. A significant number of these referrals are received from the Department of Human Resources (DHR) and the Alabama State Department of Education (ALSDE).

Purpose/Intent: To ensure that adequate and appropriate documentation is secured on all referral of individuals ages 3 – 21, to include any age appropriate psychological assessments, current IEP (including eligibility sheet), medical records, etc. To ensure that all services rendered to children are age appropriate and provided in the least restrictive setting.

Definitions: EPSDT – Early and Periodic Screening, Diagnostic and Treatment Services: Medicaid program benefit providing a comprehensive array of prevention, diagnostic and treatment service for low-income infants, children and adolescents under age 21 as specified in Section 1905(r) of the Social Security Act.

MNC - Multiple Needs Child – a child coming to the attention of the juvenile court who is at imminent risk of out of home placement or placement in a more restrictive environment and whose needs require the services of two or more of the following entities: Department of Youth Services, Department of Human Resources, Department of Education, Department of Mental Health and the Juvenile Probation Office. IEP – Individualized Educational Plan, FAPE – Free and Appropriate Public Education, LEA – Local Education Agency

Procedures:

1. Referrals of school age children will include a current IEP, inclusive of the Eligibility Page indicating the Special Education classification of said child as well as other age appropriate psychological assessments, medical records, EPSDT results (as applicable) and any other supporting documentation of the child's diagnosis.
2. Upon referral of a child from ALSDE or DHR, verification of Medicaid eligibility and Wait List status will be confirmed. If referred individual is not on the wait list the referral agent will be directed to contact the ID Call Center to initiate the referral process.
3. Documentation of all appropriate resources must have been explored and exhausted prior to individual being placed on the Wait List. If determined eligible, the referred individual will be placed on the wait list. If individual has been deemed a Multiple Needs Child relevant documentation of the MN status should be indicated.
4. If eligibility has been established and individual is currently on Wait List, referral agent will be directed to contact Director of Community Programs to request a waiver slot pending the urgency/criticality of the request.
5. If out of home placement is being requested per DMH Certification standards, placement shall occur in a facility with individuals in the same age range exclusively.
6. If specialized educational services are being requested, i.e. Glenwood or the Learning Tree, documentation of the LEA's inability to provide FAPE is required per ALSDE regulations.

7. If the LEA has indicated that FAPE can be provided, but an alternative residential setting is being requested, an RFP will be distributed to applicable DMH providers by the appropriate Regional Community Services office.

1.6.b. Waiver to Waiver Transfers

Responsible Office: System Management
Reference: Alabama Medicaid Long Term Care Division Policy
Statement: Required Elements for Waiver to Waiver Transfers
Purpose/Intent: To ensure individual health and safety without interruption in service delivery
Scope: All waiver to waiver transfers from or to another operating agency
Definitions: Targeted Case Management (TCM), Alabama Department of Senior Services (ADSS), Alabama Department of Rehabilitation Services (ADRS), Department of Public Health (ADPH)
Procedures:

1. The TCM Support Coordinator should be familiar with the services, eligibility and contact information for the other waiver programs available to individuals served.
2. The TCM Support Coordinator should ensure that eligibility requirements are met to transfer the individual from one waiver to the other.
3. When the individual requests a transfer from one waiver to another waiver, the Support Coordinator should confirm a slot is available on the other waiver by contacting the appropriate state agency's case manager/support coordinator.
4. The transferring case manager/support coordinator should work with the receiving waiver case manager/support coordinator to ensure that waiver to waiver transfer will occur smoothly without a service interruption by working closely with that case manager/support coordinator.
5. The receiving case manager/support coordinator should notify the transferring case manager/support coordinator when all paperwork has been received and the transfer paperwork is all in order.
6. The transferring case manager/support coordinator should close the case on the last working day of the month.
7. The receiving case manager/support coordinator should process the admission to the receiving waiver on the first day of the following month.
8. Waiver services should be authorized to begin on the first day of the month to ensure the individual's health and safety are not compromised.

1.6.c. Termination of Waiver

Responsible Office: System Management
Reference: Medicaid Administrative Code
Statement: Termination of waiver will follow the guidelines outlined by the Alabama Medicaid Agency and standard for all waiver programs
Purpose/Intent: To provide consistency in termination of waiver within established timeframes.
Scope: All waiver terminations
Procedures: Waiver terminations must follow the reasons and timeframes below:

1. Hospitalization-termination one full calendar month of hospitalization.
2. Nursing Home placement-termination after 48 hours of placement

3. Moved out of state-termination after 60 days out of state
4. Death-immediately following notification.
5. No longer meets eligibility requirements-immediate
6. No longer request waiver services-immediate
7. Refusal to adhere to program requirements- 30 days following written notification
8. Transfers to another waiver program-on the last working day of a month.
9. Unable to locate waiver participant-30 days after written notification to last known address remains without response.
10. Financially ineligible-immediate after notification from the Medicaid District Office.

***Terminations for those participants who are 300% cases must include written notification to the Medicaid District Office.**

1.6.d. Waiver Admission & Discharge

Responsible Office: System Management
Reference: 1915c Home and Community Based Intellectual Disabilities Waiver
Revised: May 28, 2021
Statement: The RO Waiver Coordinator completes admission to, and discharge from, the Waiver via the web-based application.
Purpose/Intent: Specific documents, data input, and reporting/recording processes are required to formally admit persons to, or discharge them from, the Waiver.
Scope: ADMH-DDD Central/Regional Offices/HCBS Waivers: ID, LAH, CWP
Definitions: LTC-2 (Notice of HP Enrollment or Termination Action), RO (Regional Office), CO (Central Office)
Procedures:

1. When a person is either admitted to, or discharged from, the Waiver, the RO Waiver Coordinator:
    a. Prints the most recent Plan of Care and, if a discharge, the LTC-2 form (both previously uploaded by the responsible Support Coordinator) from the web-based application.
    b. Selects the most recent Programs Record within the client record in the web-based application and:
        i. Sets the CM Action to "Application/Discharge/Re-Admission".
        ii. If an admission, sets the CM Action date to that of the POC.
        iii. If a discharge, sets the CM Action date to that of the LTC-2.
        iv. If a discharge, sets the Discharge Reason commensurate with the information on the LTC-2.
        v. Sets the RO Action to "Approved".
        vi. Sets the RO Action date to the current date.
    c. Completes a new RO Waiver Registration in the web-based application.
        i. Sets Consumer Assessments Review to "Discharge/Application/Readmission".
        ii. Completes other fields in the RO Waiver Registration as appropriate for admission or discharge.
        iii. Prints the RO Waiver Registration Face Sheet.

d. Scans and emails to the Mental Health Specialist II in DDD Central Office:
    i. RO Waiver Registration Face Sheet
    ii. Medicaid Eligibility Screen
    iii. If a discharge, the LTC-2 form
2. The CO Mental Health Specialist II forwards the RO Waiver Registration and Medicaid Eligibility Screen to Medicaid for approval.
    a. Upon approval, individual waiver segments are added in the Programs tab in the web-based application, as applicable.
3. The RO Administrative Assistant uploads into the web-based application the RO Waiver Registration, Medicaid Eligibility Screen, and, if a discharge, the LTC-2 form and POC.

1.6.e. Request for Proposal Seeking Services for Individuals

Responsible Office: Regional Community Services
Reference: 1915c Home and Community Based Intellectual Disabilities Waiver
Effective: October 1, 2020
Statement: When a person is approved to receive or change Waiver services/providers, a Request for Proposal to provide services is circulated to certified providers of the needed service(s).
Purpose/Intent: The Request for Proposal is prepared by the Support Coordinator with the goal of communicating essential information about the person served, such that potential providers may make an informed decision about their potential ability to successfully serve that person.
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions: RCS (Regional Community Services); Request for Proposal (RFP); BCBA (Board-Certified Behavior Analyst); BSP (Behavior Support Plan)
Procedures:

1. The RFP is prepared by the Support Coordinator within five (5) business days when:
    a. An applicant for Waiver services initially enters service.
    b. A person served on the Waiver adds a new service.
    c. A person served on the Waiver elects to change providers.
2. The RFP must identify current support needs to include the following:
    a. Social (family, caregiver, mentor, support coordinator involvement)
    b. Environmental (home layout, housemate structure, routine accommodations, etc.)
    c. Community Supports (mental health resources such as psychiatrist and/or therapist, extracurricular opportunities, etc.)
3. The RFP must also include the following essential information:
    a. Basic demographics (i.e., age, gender, city/county of residence, height/weight)
    b. Current and historical behavioral presentation
    c. BCBA/BSP involvement
    d. Psychiatric diagnoses
    e. Medical diagnoses
    f. Medical history
    g. Current medications
    h. Medication self-administration ability
    i. Communication skills

j. Mobility skills
k. Self-care skills
l. Adaptive equipment needs
m. Most recent intellectual and adaptive testing data
n. Current Waiver services received

4. Immediately upon completion of the RFP, the Service Coordinator circulates it, via email, to all providers local to the person and who offer the needed service(s). Interested providers are afforded seven (7) business days to respond to the circulated RFP.
5. If the RFP is circulated and receives no responses from providers, it will be circulated a second time, again with a response time frame of seven (7) business days.
6. If the RFP is circulated a second time and receives no responses from providers, the Service Coordinator submits the RFP to the RCS Placement Coordinator and, within three (3) business days, the Placement Coordinator reviews it for completeness and accuracy.
7. The Placement Coordinator will consult with the Community Services Director and the Support Coordinator to identify prospective providers with program vacancies and compatible services offered. The Placement Coordinator will directly contact these prospective providers to propose the possibility of serving the person in need of services.
8. In the event that no local provider responds to the RFP(s), the applicant/person served may elect to have the RFP circulated in other fiscal Regions, for consideration by providers in those areas. If this is the decision of the person, the Placement Coordinator in the Region of the person's residence will share the RFP with the Placement Coordinator(s) in the Region(s) encompassing any other areas the person chooses to seek services, and the RFP process noted above will then be followed there.

CHAPTER 2
INDIVIDUAL RIGHTS

2.1 Appeals

2.1.a. Waiver/Wait List Eligibility Appeals

Responsible Office: Office of Community Programs, Support Coordination, currently Office of PBS
Reference: Alabama Administrative Code, Alabama Medicaid Administrative Code
Statement: The Alabama Department of Mental Health (ADMH) is responsible for the assessment, evaluation of admissions, readmissions, and annual redeterminations for eligible participants receiving home and community- based services (HCBS) in accordance with the provisions of the Home and Community-Based Waiver for Persons with Intellectual Disabilities.
Purpose/Intent: The process of appeals is one in which cases are reviewed, where HCBS waiver applicants and related parties request a formal change to an official decision. Appeals function both as a process for error correction as well as a process of clarifying and interpreting the criteria and standards by which the original decision was rendered.
Scope: Applicants for the ADMH HCBS Waiver/Wait List, and ADMH-DD staff that are responsible for eligibility determinations.
Definitions: Appeal- a formal request that a decision, as in a legal or official one, be changed.
Procedures:

1. If the applicant is determined ineligible, the applicant will receive a memorandum regarding denial of eligibility. This notification will state that the application has been denied specifying the reason (it will describe the statutory and/or regulatory requirement that has not been met).
2. The appeal process begins with a written request from the applicant, either to the Division of Developmental Disabilities or to the Alabama Medicaid Agency, with specific timelines involved for each. If the applicant appeals first to the Division of Developmental Disabilities within 15 days of receipt of denial letter, he or she will be entitled to a review by the Associate Commissioner, who will produce a written determination. If the individual is dissatisfied with that determination, he/she has the right to appeal to the Alabama Medicaid Agency within 60 days of notice of action. The notification fully explains the process of appeal to both agencies.
3. An individual who is denied Home and Community-Based Services based on Rule No. 560-X-35-.03, may request a fair hearing in accordance with 42. C.F.R. 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code.
    a. Recipients will be notified in writing at least ten days prior to termination of service.
    b. A written request for a hearing must be filed within sixty days following notice of action with which an individual is dissatisfied.
4. In either situation the individual must complete Exhibit 2.1.a.

2.1.b. Appeals Process for Adverse Actions- Services Decisions

Responsible Office: System Management
Reference: 42-CFR 431.210 (Subpart E); 560-X-3 Medicaid Administrative Code; Appendix F ID and LAH Waivers

Statement: ADMH/DD Division provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are denied the service(s) of their choice or the provider(s) of their choice; or, (b) whose services are denied, suspended, reduced or terminated. ADMH/DD Division provides notice of action as required in 42 CFR §431.210.
Purpose/Intent: Compliance with Federal Regulations regarding individual adverse actions
Scope: Service requests denied, suspended, reduced or terminated
Definitions: RFA (Request for Action), CSD (Community Services Director)
Procedures: The DD Division will adhere to the following steps in appeals requested regarding any adverse action taken by the regional office.

1. Written advanced notification to the individual or responsible person must include:
    a. Date of Notice
    b. The specific adverse action being taken
    c. Specific information about the reason(s) for the adverse action
    d. The effective date of the action
    e. The individual's right to request an informal conference or fair hearing with Alabama Medicaid and the procedures for doing so
    f. Notice that an informal conference is not an alternative to a fair hearing
    g. If the individual requests the informal conference or fair hearing within ten (10) days of receiving the notice of adverse action, service involved will continue at the current level according to the plan of care until the appeal process has been exhausted. Services requested, denied and/or not currently on the plan of care will not be provided during the appeal process.
    h. Point of contact if there are questions regarding the action
2. The written request from the individual receiving notification of any adverse action will be sent to the Associate Commissioner of the DD Division. The Associate Commissioner will choose a panel of three members to review the denied RFA.
3. The three-member panel will consist of a CSD from another regional office and two persons within the DD Division employed at the Central Office.
4. The panel will review the denied RFA and other information individually making note of any questions that may arise and complete the Review of Denial Form.
5. A teleconference will be scheduled with the 1) participant/family/guardian/representative, 2) panel, 3) CSD responsible for approving/denying RFA's in the participant's Region, 4) Program Administrator for AMA/LTC ID/LAH Waiver (if warranted) and 5) participant's support coordinator.
6. The teleconference will provide the participant/family/guardians time to offer any information to the panel that may change the outcome of the RFA decision. The panel will also utilize the time to ask any specific questions to either the participant/family/guardians, the CSD or the support coordinator that may be needed to provide more clarity and indicate responses on the Review of Denial Form.
7. Following the teleconference, the panel will make recommendations in writing to the Associate Commissioner of the DD Division to reverse or uphold the original decision made by the CSD through completion and submission of the Review of Denial Form.
8. The Associate Commissioner will notify the participant/family/guardian of the decision in writing.

Due process appeal procedures will be included with the response from the Associate Commissioner in the event the participant/family/guardian remains in disagreement with instructions on how to request a fair hearing.

2.2. Dissatisfaction of Services

Responsible Office: Support Coordination
Reference: 42 CFR 441.302(d). ID and LAH HCBS Waivers
Statement: Persons enrolled in one of the Alabama Medicaid Home and Community Based Waiver programs for people with intellectual disabilities will receive written notification of their rights to a review of their case and/or a fair hearing if they are dissatisfied with the services he/she is receiving.
Purpose/Intent: The Dissatisfaction of Services form is a disclosure required by Alabama Medicaid to ensure a person enrolling or already receiving HCBS waiver services and their legally authorized representative are aware that they have the right to due process should they become dissatisfied with Medicaid funded services.
Scope: Applies to a person who is dissatisfied with his/her services under the Medicaid Home and Community-Based Waiver (Living at Home Waiver or Waiver for Persons with Intellectual Disabilities); A Legal Representative for a person who receives services under a Home and Community-Based Waiver; Support Coordinators
Definitions: People – HCBS Waiver participants; Support Coordinators – Formerly referred to as Case Managers; Regional Community Services Office staff – One of five regional offices located throughout the state; Due Process – Medicaid review of the case/complaint and/or a Fair Hearing; HCBS – Home and Community-Based Services
Procedures:

1. The Dissatisfaction of Services form (See Exhibit 2.2) must be completed at the time a person is admitted to Medicaid HCBS Waiver Services. It may be completed more frequently, i.e. annually, when a person changes waivers or services.
2. A person who is dissatisfied with his/her services under the Medicaid Home and Community-Based Waiver program (Living at Home Waiver or Waiver for Persons with Intellectual Disabilities) may notify the Alabama Medicaid Agency giving the reason for the dissatisfaction and ask for either a conference or a review of the case by the Alabama Medicaid Agency. At the conference, the person may present the information or may be represented by a friend, relative, attorney or other spokesperson of their choice.
3. A written request for a hearing must be filed within sixty (60) days following the action with which the person is dissatisfied. He/she, his/her legally appointed representative or other authorized person must request the hearing and give a correct mailing address. If the request for a hearing is made by someone other than the person who wishes to appeal, the representative must make a definite statement that he has been authorized to do so by the persons for whom the hearing is being requested. Information about hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the persons will be arranged. If the person is satisfied before the hearing and wants to withdraw his/her request, he/she or his/her legally appointed representative or other authorized person should write the Alabama Medicaid Agency that he/she wishes to do so and give the reason for withdrawing.
4. The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy, which requires an automatic change adversely affecting some or all recipients. When benefits are terminated, they can be continued if a hearing request is received within ten (10) days following the effective date of termination, unless there are unnecessary delays by the person requesting the hearing for this representative. If benefits are

continued pending the outcome of the hearing and the Hearing Officer decided that termination was proper, Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.

5. Written request for reviews and fair hearings should be sent to: Alabama Medicaid Agency, Long Term Care Division, P.O. Box 5624, 501 Dexter Avenue, Montgomery, AL 36103-5624.

2.3. Informal Conference- Services

Responsible Office: System Management
Reference: 42CFR-431.200; ID Waiver; LAH Waiver; Medicaid Administrative Code
Statement: People receiving Waver Services will be provided appeal rights regarding decisions by the Operating Agency that adversely affects service provision.
Purpose/Intent: To ensure rights of waiver participants
Scope: Applicable to all waiver services; Regional Community Services Offices, Support Coordination agencies, families
Definitions: Adverse action means any decision that negatively impacts the waiver participant. This includes denials, reductions, delays in, or termination of any waiver service.
Procedures:

1. The Regional office denies the participant's request for service.
2. Responds in writing notifying the waiver participant of the decision and why the decision was made. Letters should include the effective date of the action and must also provide the participant his right to appeal the decision and the steps involved.
3. The waiver participant has 60 days to request an appeal. In the case of termination or reduction of services, the person must request the appeal within 10 days (working or calendar) of notification from the ADMH Regional Office. If received within the 10-day timeframe, service will continue at the current level until the appeal process has been exhausted.
4. Upon request of an informal conference to the ADMH/DD Associate Commissioner will schedule within 15 working days of receipt of the request.
    a. The Associate Commissioner will choose a panel of three members to review the denied RFA.
    b. The three-member panel will consist of a CSD from another regional office and two persons within the DD Division employed at the Central Office.
    c. The Associate Commissioner sets a date for the informal conference within 15 working days of the receipt of the request for informal conference.
    d. The panel will review the denied RFRA and other information individually making note of any questions that may arise and complete the Review of Denial Form.
    e. A teleconference will be scheduled with the 1) participant/family/guardian/representative, 2) the panel, 3) the CSD responsible for approving/denying RFRA's in the participant's Region, 4) the Program Administrator for AMA/LTC ID/LAH Waiver (if warranted) and 5) the participant's case manager.
    f. The teleconference will provide the participant/family/guardians time to offer any information to the panel that may change the outcome of the RFA decision. The panel will also utilize the time to ask any specific questions to either the participant/family/guardians the CSD, or the case manager that may be needed to provide more clarity and indicate responses on the Review of Denial Form.
    g. Following the teleconference, the panel will make recommendations in writing to the Associate Commissioner of the DD Division to reverse or uphold the

original decision made by the CSD through completion and submission of the Review of Denial Form.

h. The Associate Commissioner will notify the participant/family/guardian in writing of the decision in writing of the decision within 15 working days of the informal conference.

i. Due process appeal procedures to request a Medicaid Fair Hearing will be included with the response from the Associate Commissioner in the event the participant/family/guardian remains in disagreement.

2.4. Other

2.4.a. Forensic Cases

Responsible Office: Office of PBS, Forensic Outpatient program
Reference: ADMH Administrative Code, Alabama Psychological Association, ADMH Legal standard
Statement: In the case of Atkins v. Virginia (2002), the United States Supreme Court effectively prohibited the execution of persons with intellectual disabilities by deciding that doing so violated the Eighth Amendment ban on cruel and unusual punishment. People with intellectual disabilities frequently know the difference between right and wrong but, by definition, they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand others' reactions. Their deficiencies do not warrant an exemption from criminal
sanctions but diminish their personal culpability.
Purpose/Intent: The Alabama Department of Mental Health may be so ordered by the circuit court of Alabama to facilitate the process for and conduct an Atkins Evaluation for an individual. A certified forensic examiner (as defined and credentialed by ADMH) and/or licensed expert in the field of intellectual and developmental disabilities must complete this evaluation.
Scope: ADMH legal staff and ADMH-DD administration who may receive and respond to court orders for Atkins Evaluation.
Definitions: Atkins- In 2002, the United States Supreme Court held in Atkins v. Virginia that the execution of persons with intellectual disabilities is unconstitutional because it violates the Eighth Amendment's prohibition against cruel and unusual punishments. The evaluation examines a person's culpability with regard to their intellectual ability and disabilities.
Procedures:

1. A court order for an Atkins (forensic) evaluation is received and processed first by ADMH legal department.
2. The Forensic Outpatient program coordinator receives the order from legal and facilitates assignments to a DMH contract forensic examiner in the community to complete evaluation.
3. In some cases, the Director of Psychological and Behavioral Services may be assigned the court ordered evaluation to complete, granted it does not pose ethical conflicts.
4. Coordination of date, time, location of test session will be coordinated through the Forensic Outpatient program and/or Regional Community Services Director and assigned evaluator.
5. Once evaluation is complete, final report is submitted to the Forensic Outpatient Program coordinator.
6. Evaluator may be asked to appear in court and provide testimony related to the Atkins evaluation report submitted.

CHAPTER 3
INDIVIDUAL SUPPORT PLANNING AND IMPLEMENTATION

3.1. Plan of Care

Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30-.13; 1915 Home and Community Based Intellectual Disabilities Waiver
Statement: The Plan of Care outlines specific services requested by the individual and/or family, to be implemented by their chosen service provider.
Purpose/Intent: The Plan of Care enables authorization of services (i.e. volume, frequency, and start date) and provides a current record of the services authorized for a person.
Scope: Director of Community Programs, Regional Community Services, Support Coordinators, Providers
Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); RFA (Request for Action); CSD (Community Services Director); POC (Plan of Care); RCS (Regional Community Services)
Procedures:

1. The Plan of Care (POC) is generated/updated by the Support Coordinator whenever a new service, or a change in services, is approved by RCS or otherwise enacted via the Request for Action policy.
2. The Support Coordinator generates the POC via the Plan of Care tab in DDD IMS and:
    a. Records the Begin date of the POC as the date of the annual Person-Centered Planning Meeting.
    b. Inputs each service chosen and approved, as applicable, including the provider of each service, using the Act Codes to indicate services added or stopped at the time of the present POC.
    c. Records the Start Date of individual services as the date of RFA approval by RCS or, if RCS approval is not required, the date the Plan of Care is modified.
    d. Records the End date of the POC and of individual services as one year from the Begin/Start date.
    e. Obtains the necessary signatures indicated on the POC.
3. The Support Coordinator uploads the POC to the Notes tab of DDD IMS and:
    a. Tags the Waiver Coordinator as a Note Recipient on the Note to which the POC is attached.
4. The Waiver Coordinator:
    a. Reviews the POC to verify that it is completed correctly, noting any needed changes to the Support Coordinator via DDD IMS Notes.
    b. Selects the Note as "Complete" upon verification of POC accuracy, then tags the Fiscal Officer and Support Coordinator as Note Recipients.
5. The Fiscal Officer authorizes services in DDD IMS as indicated on the POC.

CHAPTER 4
SUPPORT COORDINATION (CASE MANAGEMENT)

4.1. Funding for Support Coordination Agencies

Responsible Office: Administrative and Fiscal Operations
Reference: N/A
Statement: Setting amounts for funding support coordination in the Department of Mental Health DD
Division Purpose/Intent: To establish a methodology to determine the amount of budget for support coordination to be provided to contracting agencies during the fiscal year.
Scope: This guideline applies to fiscal managers of the Department of Mental Health DD Division
Definitions: Support Coordination agencies were formerly referred to as Case Management agencies
Procedures: Each year when preparing the operations plan for the upcoming fiscal year regional fiscal managers will run the Units of Service Summary report or equivalent through the Department's web-based billing system. Days specified in the report will be 9/1 of the prior calendar year through 5/31 of the current calendar year. This report will identify the number of distinct individuals served by each program in that time period. Fiscal managers will use that number to calculate the number of dollars to contract with the agency by multiplying the number of distinct individuals identified by the number of currently allocated hours and the current support coordination dollar rate.

During the fiscal year a full allotment of annual hours will be added to the budget of the contracting agency for each new person receiving their services. The full allotment of hours will be added regardless of when in the fiscal year the person begins services.

4.2. Request for Action/Services

Responsible Office: System Management
Reference: ADMH/DDD Operational Procedures
Revised: March 5, 2021
Statement: Following a team meeting where all appropriate persons attend, ADMH/DDD requires the support coordinator to submit the **REQUEST FOR ACTION (RFA)** form to the Regional Office Community Service Director or Designee for any addition to a Plan of Care for the following services. The Regional Office should make the determination within no more than **seven (7) working days** to expedite service delivery.

1) Assistive Technology
2) Environmental Accessibility Adaptations (EAA)
3) Specialized Staffing (SS)*
4) Positive Behavior Supports (PBS)
5) Support Services not included in the most recent Person-Centered Plan
6) Changes in staffing levels for participant in Residential Services
7) Increases in the original units authorized for any service
8) Increases over 12 hours per day for personal care
9) Any service not included on the Person-Centered Plan or on the Plan of Care (Day Habilitation, Community Experience, OT, PT, ST, Employment Support, etc.)
10) All Self-Directed changes

Purpose/Intent: To expedite the RFA process
Scope: ADMH-DDD Central/Regional Offices, Support Coordinator Services
Definitions: RFA (Request for Action) - Additions to an individual's plan of care; DDD IMS (Division of Developmental Disabilities Information Management System)

PROCEDURES FOR SUPPORT COORDINATOR

1) Hold a team meeting of appropriate persons; obtain signatures on revised plan of care.
2) Check Medicaid State Plan Services (SPS) and other insurance to ensure an item is not covered
3) Obtain required supporting documentation as necessary (prescriptions, medical documentation, quote, ICAP, etc.)
4) Complete the RFA Form with a detailed assessment (formal or informal) that supports this request
5) Submit the RFA Form to the Regional Office electronically through ADIDIS
    a) Include medical documentation
    b) Quote for service
6) Add service to the plan of care using the following format:
    a) Provider Name
    b) Service Code
    c) Service Name
    d) Unit
    e) Unit Type
    f) Cost
    g) Start Date

h) End Date

7) Submit RFA form to the Regional Office through ADIDIS

PROCEDURES FOR REGIONAL OFFICE

1) Verify all information is included on the RFA. If not, return to support coordinator with a note in the **NEEDED INFORMATION** section of the form. Include the date returned to the support coordinator.
2) Verify the documentation supports the need for service
3) Approved; generate letter to the participant with a copy to the Support coordinator
4) Denied; generate letter to the participant accompanied by appeal rights with a copy to the Support coordinator
5) Sign and date the form and add dates to Plan of Care
6) Mail original letter to participant, copy support coordinator (upload in ADIDIS), copy provider (via email), and copy
   the Executive Director of the case management agency
7) Copy to Fiscal Officer in the Regional Office to authorize service through ADIDIS

The provider must submit to the regional office CSD information that all staff providing Specialized Staffing, either medical and/or behavior, has met the training requirements as outlined in the waiver document. When changes in staff occur, the provider must submit to the Regional Office that the new employee has been trained and is qualified to provide the service as outlined in the waiver documents.

Services cannot be initiated without an approved RFA.

An RFA **is not** required for in the following situations. A team meeting is not required in these instances. The process should be completed in no less than five (5) days to ensure timely delivery of services:

1) Unit currently authorized and on the Plan of Care that requires a change.
2) Service documented as an anticipated service in the participant's Person-Centered Plan.
3) All address changes in residential providers or provider sites.
4) Change in providers.

PROCEDURES FOR SUPPORT COORDINATOR

Ensure documentation is evident in the Person-Centered Plan or is on the **Plan of Care and authorized**.

1) Make changes to the participant's Plan of Care
   a) Include the End Date for the previous units and begin date for the new services
   b) Place new service on the participant's plan of care including start and end date using the same format as above
2) Submit note into ADIDIS with copy to the Waiver Coordinator marked ***Alert***.
3) Waiver Coordinator will verify the Plan of Care has been updated; if not, return to support coordinator to correct.

4) Once approved by Waiver Coordinator, mark the note as ***Complete*** copying the support coordinator and the Fiscal Officer.
5) The Fiscal Officer authorizes the service.
6) Support coordinator will notify the provider of the start date of service.

4.3. Redetermination

Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30.14 Level of Care Determination for Medicaid Waiver Programs, 1915c Home and Community Based Intellectual Disabilities Waiver
Effective: November 19, 2020
Statement: Redetermination of Waiver eligibility is conducted annually, utilizing new and updated documentation of eligibility data.
Purpose/Intent: The redetermination process is implemented annually to ensure continued eligibility for Waiver
services and to verify that services identified as needed are being provided appropriately.
Scope: Director of Community Programs, Regional Community Services; Support Coordinators; DDD Central Office
Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); ICAP (Inventory for Client and Agency Planning); LOC (Level of Care); MSIQ (Medicaid Database)
Procedures:

1. **The Support Coordinator:**
    a. Completes supporting documentation uploaded to the DDD IMS Notes tab:
        i. Signed Plan of Care
        ii. Dissatisfaction of Services
        iii. Freedom of Choice
        iv. Person Centered Assessment and Plan
        v. Physical or RN Assessment (only until physical is obtained)
        vi. ICAP
        vii. Psychological
    b. Completion of supporting documentation no later than the 15th day of the month prior to the expiration of the Waiver determination.
2. **The Waiver Coordinator:**
    a. Downloads the Redeterminations Due Report for the month at hand from DDD IMS, via the Reports tab (select Type: MR Clinical).
    b. Reviews supporting documentation uploaded to the DDD IMS Notes tab by the Support Coordinator:
        i. Signed Plan of Care
        ii. Dissatisfaction of Services
        iii. Freedom of Choice
        iv. Person Centered Assessment and Plan
        v. Physical or RN Assessment (only until physical is obtained)
        vi. ICAP
        vii. Psychological
    c. Prints the Level of Care (LOC) form from the **Demographics** tab.
        i. Ensures eligibility is evidenced by at least 3 areas of life activity checked on the LOC.
    d. Prints the person's MSIQ screen and checks the **Fund Eligibility** to verify active status for Medicaid.

e. Reviews the Waiver documents in the **Clients** tab of DDD IMS [referenced tabs are in bold below]:
    i. Opens the **Diagnosis** tab to ensure information there is consistent with the IQ level on the Level of Care (LOC)
    ii. Reviews the Eligibility Assessment under the **Assessments** tab (Psychological/ICAP/ABS)
        - Ensures it was completed within 60 days of the redetermination date.
        - Ensures the referenced IQ score is less than 70.
        - Ensures the referenced ICAP was completed within 2 years and review at least annually.
        - Ensures the referenced ICAP score is less than 85.
    iii. Reviews the Summary of Habilitation record in **Assessments** to ensure the LOC limitations match identified deficits.
    iv. Reviews the **Plan of Care** to ensure the redetermination/initialed field is marked as "Yes" and to ensure Waiver services provided match those represented in **Authorizations.**

3. **If missing or incorrect information is noted during the redetermination process, or if new information suggests eligibility is in question, the Waiver Coordinator documents such in the Notes tab and tags the responsible Support Coordinator and their supervisor for follow-up.**
4. **If all is correct and eligibility remains evident, the Waiver Coordinator:**
    a. Duplicates the previous year's RO Waiver Registration in the **Assessments** tab, updating for the current date and denoting as "Complete".
    b. Enters the Waiver record in the **Programs** tab and sets the RO Action to "Approved".
    c. Signs and dates the LOC.
    d. Scans and emails to the Mental Health Specialist II in DDD Central Office:
        i. RO Waiver Registration
        ii. MSIQ Screen
    a. Scans and uploads LOC documents to the Notes tab in individual records in DDD IMS, tagging the responsible Support Coordinator.
5. **The Mental Health Specialist II forwards the RO Waiver Registration and MSIQ Screen to Medicaid for approval.**
    a. Upon approval, individual waiver segments are added in the **Programs** tab in DDD IMS.
6. **The Regional Administrative Assistant:**
    a. Prints the LTC-2.
    b. Files the RO Waiver Registration, MSIQ Screen, LOC, and LTC-2.
7. **If the ICAP score is in need of change from previous administration, the waiver coordinator will notify the Fiscal Manager.**

4.4. Summary Program of Habilitation

Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30.14 Level of Care Determination for Medicaid Waiver Programs, DDD IMS User Guide
This is being included in the Person-Centered Plan.
Statement: The Summary Program of Habilitation is a digital form accessible in the Assessments tab of DDD IMS.
Purpose/Intent: The Summary Program of Habilitation utilizes information collected via standard assessments to identify the assets, deficits, and maladaptive behaviors of the person, so as to establish an initial habilitation plan.
Scope: Director of Community Programs; Regional Community Services; Support Coordinators
Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); ICAP (Inventory for Client and Agency Planning); LOC (Level of Care form)
Procedures:

1. **The Support Coordinator completes the Summary Program of Habilitation at the time of intake to Waiver services and annually as redetermination information is prepared (at least 30 days prior to the person's redetermination date).**
    a. The following fields are auto-populated directly from information on the LOC:
        i. AAMR Defined Measured Intellectual Level
        ii. Adaptive Behavior Level
    b. Assets must reflect skills the person can perform independently.
    c. Deficits must reflect the areas identified as limitations on the LOC, with added specificity.
    d. Maladaptive behaviors must reflect documented behaviors that are harmful to the person and/or others or otherwise interfere with daily functioning.
    e. The Initial Habilitation Plan must include goals for training to improve each of the identified skill deficits.
2. **The Waiver Coordinator reviews the Summary Program of Habilitation during the redetermination process to ensure that the information therein is consistent with that reported on the LOC.**

4.5. Monitoring - Individual Experience Assessment Survey

Responsible Office: Support Coordination
Reference: 2014 HCBS Rule
Statement: The Home and Community Based Settings (HCBS) Rule that went into effect March 17, 2014, set forth by The Centers for Medicare and Medicaid Services (CMS,) requires that states review and evaluate the quality of HCBS supports and services experienced by persons receiving these services. Upon initiation of waiver supports and services AND at least annually thereafter, the Support Coordinator shall assess each person's experience in
receiving Medicaid HCBS waiver services.
Purpose/Intent: The purpose of this guideline is to specify the State's procedures and timelines for assessing and measuring each person's level of awareness of and access to exercising their rights, privacy requirements and life experiences in their day-to-day activities while living in their communities. The survey results will be used to assess changes that may be needed to improve the experience people have when receiving Home and Community Based Services. This survey will also help ensure Alabama is compliant with the HCBS Settings Rule.
Scope: Support Coordinators, people determined to require a level of care for the ID, LAH and future waivers administered by the DMH DDD, Regional Community Services (RCS) Monitors and Support Coordination Liaisons
Definitions: People – HCBS Waiver participants; Support Coordinators – Formerly referred to as Case Managers, employed by 310 Boards; ID waiver – Intellectual Disabilities waiver; LAH waiver – Living-at-Home waiver
Procedures:

1. Support Coordinators shall assess people moving into NEW settings within 5 days before or after day 60 of enrollment in waiver services and/or move into the new setting. This assessment (See Exhibit 4.5) should be coordinated with the Regional Office's validation Report of 100% compliance with the 2014 HCBS Settings Rule by the assigned Monitor in the same time-frame.
2. For persons currently receiving Medicaid Waiver services, the initial IEA will be completed at the time of their first annual PCP assessment/meeting scheduled after the May 1, 2019 implementation date, and annually thereafter.
3. Participants in the IEA shall include the person and his or her family members and/or representative, as appropriate. The person's input should be obtained first, with input from others involved used when the person is not able to respond to one or more of the questions independently. Service provider staff may participate as requested by the individual and his or her family and/or representative.
4. Results are submitted to the provider and the Regional Office Monitor within at least TEN (10) business days of the date the survey was completed. [Original to the Regional Office Monitor, copies to the provider agency(s), Support Coordination Liaisons and Support Coordinator].
5. Follow up on any area NOT in Compliance shall be completed within TEN business days of date of survey. Follow up may consist of revision of the PCP by the Support Coordinator or remediation by the provider with completion verified by the Regional Office Monitor and Support Coordination Liaisons.
6. The person's Support Coordinator, as applicable, shall address any issues regarding compliance with the HCBS Settings Rule or other concerns identified during the IEA. Each NO response

should be investigated to determine if it is appropriately supported by the PCP or if it is truly Not in Compliance. Specific remediation should occur for any response that is determined to be Not in Compliance.

7. Initial surveys (original) should be forwarded to the Regional Office Monitors and Support Coordination Liaisons. Thereafter, only surveys reflecting non-compliance should be forwarded to Regional Office Monitors and Support Coordination Liaisons. Provider agency(s) shall receive copies of initial and annual assessments.

NOTE: If Personal Care Supports/Services are provided to a person in a setting that is NOT provider owned or operated (i.e. their own apartment/home, family home or they reside with someone considered a natural support), **a response of NO in Section E does not automatically indicate Not in Compliance.**

4.6. Recoupment Policy

Responsible Office: System Management
Reference: RFA Procedures O.G 4.2
Statement: Support Coordinator agency found out of compliance with the RFA procedures may be subject to recoupment of funds for repeated violations to the RFA process.
Purpose/Intent: To protect the program integrity and demonstrate financial accountability.
Scope: Regional Offices, Support Coordination/Case Management Agencies, Providers, Central Office
Definitions: RFA: Request for Action
Procedures: Steps to protect integrity of Support Coordination service delivery relating to unit utilization.

1. Provide training to the following Regional Staff about the recoupment process to include the following: Technical Assistance professionals, Community Service Directors, Waiver Coordinators, Support Coordinator Liaisons and Fiscal Officer.
2. Provide training to Support Coordinators on the recoupment process.
3. The Support Coordination Liaison/Monitor will conduct an initial review 60 day after training is provided to community Support Coordinators.
4. Based on results of the initial review, they will provide additional training where needed along with Technical Assistance.
5. Provide a follow-up review 60 day from the date of the second training and Technical Assistance.
6. If concerns are reflected in the second review (after second training and/or additional Technical Assistance), the Regional Office Support Coordinator Monitor will make recommendations to the Central Office Technical Assistance Team (Director of Systems Management, Fiscal Officer and the Associate Commissioner or their designee) to recoup funds as appropriate.
7. The Central Office Fiscal Manager will recoup funds as determined necessary. The Department's internal auditor may be called upon to evaluate findings and make recommendations as needed.
8. Ongoing monitoring will be provided through the Support Coordination/Case Management Monitoring tool.

4.7. Conflict Free Support Coordination/Case Management Services

Responsible Office: Developmental Disabilities Division
Reference: CMS Regulations 42 CFR 441.301 (c) (1) (vi), Affordable Care Act
Effective: November 1, 2020
Statement: The Alabama Department of Mental Health Division of Developmental Disabilities (DDD) shall ensure that providers of Home and Community Based Services (HCBS) or those who have an interest in providing these services and/ or those who are employed by a provider of HCBS do not also provide support coordination services or develop person centered plans for the person receiving HCBS. Exception: Exception to this policy is granted when the DDD determines that the only willing and qualified entity to provide support coordination services and/or develop person centered service plans in a geographic area (county) also provides HCBS; known as a sole provider for the purposes of this policy.
Standards:

1. When the DDD determines there is a sole provider of both support coordination and HCBS in a geographical area (county), the DDD shall seek to identify and procure a qualified support coordination provider to establish conflict free support coordination in the conflicted area.
2. If no qualified support coordination provider is identified for the service area, the DDD may seek to employ service coordinators and directly provide services for the conflicted area.
3. If it is established there are no qualified providers or the DDD is unable to employ service coordinators for the conflicted area, the DDD shall verify the sole provider status and establish robust monitoring and oversight procedures, including conflict of interest protections.
4. Conflict of Interest Protections shall ensure:
    A. Clinical or other non-financial eligibility determination is separate from direct services.

    B. Support coordinators and professionals who evaluate a person's needs for services are not related to the individual, their paid caregivers, or anyone financially responsible for the individual.

    C. Support coordinators are not financially responsible for the person receiving services and are not empowered to make health-related decisions on behalf of the person served.

    D. There are clear and accessible procedures for persons receiving services to assert grievances and/or appeals concerning eligibility determinations, choice and service quality, provisions and outcomes. Outcomes related to these procedures are adequately tracked monitored and implemented.

    E. Quality Management and Improvement strategies and measures are utilized to track and address the person's experiences and satisfaction related to support coordination. These strategies shall include meaningful engagement of stakeholders including, persons served and their family members, advocates, providers, DDD staff and coordinators.

F. Under no circumstance should an agency providing support coordination house a support coordinator within another provider agency with the sole purpose of providing coordination services to individuals receiving services in that facility.

G. Under no circumstances shall there be undue influence over goals, compromised individual choice of services, misaligned financial incentives or provider self-referral.

Scope: Support Coordinator Services; ADMH-DDD Central/Regional Offices

Procedures:

1. SOLE PROVIDER CONTRACTS

   A. DDD shall amend the contract of any provider entity that has been determined to be a sole provider. The amendment shall include a statement agreeing that there will be division of support coordination services and HCBS and shall be signed by the provider.

   B. The respective DDD Regional Office shall be notified of the amendment and shall increase monitoring.

   C. Violation of the amendment shall result in automatic placement on provisional certification status and notification to the DDD Central Office.

   D. Failure to take corrective action shall result in breach of contract and initiation of the decertification process.

2. CHOICE

   A. The DDD Central Office and Regional Office shall jointly develop a disclosure form to be signed by each person to be served by the sole provider denoting their choice in service providers.

   B. The person's choice form shall include a list of all provider agencies that the person can choose to deliver services.

   C. The choice form shall be completed at the time of the person's initial eligibility determination, annually thereafter at the time of redetermination, at readmission and at any time during the person's eligibility period that a change in services occurs.

   D. The person's choice form shall be filed in the person's case file.

3. MONITORING

   A. The DDD Office of Support Coordination shall monitor an entity determined to be a sole provider at least quarterly, preferably unannounced, or at any time for cause.

B. In addition, the Office of Support Coordination, Regional Community Services, and Office of Certification shall review the provider entity to ensure that the supervision of support coordinators and supervision of those providing services are separated administratively.

C. All monitoring findings and reviews shall be documented by the Office of Support Coordination, Regional Community Services, and Office of Certification.

D. Violations shall result in automatic placement on provisional certification status and notification to the DDD Central Office. Provisional status may be removed once requirements for conflict-free services are met.

E. Failure to take corrective action shall result in breach of contract and initiation of the decertification process.

4. GRIEVANCE RESOLUTION

A. Contact information and process to resolve problems with a support coordinator and/or support coordination shall be provided at least annually, in writing, to the person served. The person shall sign a copy of the resolution process form which shall be placed in the person's case file. A copy of the form shall also be provided to the person for his/her personal files and future reference.

B. Contact information for ADMH-DDD offices to be used by participants in seeking resolution to problems with support coordination shall be placed in the provider location, easily visible to persons served. Such information shall also be posted on the ADMH-DDD website.

C. If the person served has a problem with his/her support coordinator or service coordination, the person shall contact the DDD Central Office, DDD Regional Office Director or the ADMH Advocacy Office for resolution. An investigation shall be conducted, and problem resolved by the respective office.

4.8. Support Coordination Guideline

Responsible Office: DDD HCBs Waiver Service Providers/Support Coordination Services/ADMH-DDD Central/Regional Offices
Reference: Alabama Administrative Code 580-5-XX, Support Coordination Quality Review and Certification Standards, 4.7 Conflict Free Support Coordination/Case Management Services, AC 580-5-30, AC 580-1-2 Administrative standards for 310 Boards, Support Coordination Scope of Service, Chapter 580-3-26, OG 7.3 Comprehensive Support Systems CSS Teams.
Effective: October 1, 2020
Revised: May 1, 2021
Purpose/Intent: The purpose of this policy is to provide direction and information on Support Coordination operational requirements and procedures. Support Coordination operations will conform to all applicable Federal and State Medicaid Waiver and Home and Community Based Services Setting rules.
Scope: DDD HCBS Waiver Service Providers; ADMH-DDD Central Regional Offices; Support Coordinator Services
Procedures:

1. **Support Coordination Agency Operational Requirements:** The following operational requirements are established for all Support Coordination Agencies.
    a. Support Coordination Agencies will comply with the operational requirements found in the Scope of Service. (Fy21 Contract: EXHIBIT DD-4 TCM: Scope of Service – Support Coordination Agency ID/LAH Waivers)
    b. Support Coordination Agencies will comply with the Administrative Standard for 310 Boards found in AC 580-1-2.
    c. Support Coordination Agencies will provide conflict free Support Coordination/Case Management services in accordance with HCBS Setting Rule.
    d. Support Coordination Agencies will have written policies and procedures for recruiting and hiring staff in accordance with all applicable laws and meet requirements outlined in AC 580-5-33-.10.
2. **Support Coordination Qualification and Training Requirements:** The following education and trainings required to be a Support Coordinator:
    a. Possess a Bachelor's degree in a human services field: Preference should be given for experience working with individuals with intellectual individuals and/or working in support coordination, case management, or roles with similar responsibilities. Human Service field includes the following disciplines: Social Work, Psychology, Criminal/Juvenile Justice, Special Education, Sociology, Speech Education, Rehabilitation, Counseling, Speech Pathology, Audiology, Nursing, Physical or Occupational Therapy, and any related academic disciplines associated with the study of Human Behavior, Human Skill-Development, or Basic Human Care Needs. (ID/LAH Waiver: Appendix D)
    b. Support Coordinators must complete a Support Coordination training program approved by DDD and the Alabama Medicaid Agency within (6) months of beginning employment unless training is needed before the staff can sagely provide the service. (Scope of Service Section 5.5)

3. **Effective Person-Centered Planning Practices:** The following practice are established for all Support Coordination Agencies
    a. Use of most integrated setting:
        i. Service selection, as part of identifying strategies to achieve the person's desired life and defined outcomes during the person-centered planning process, will focus on community-based service options prior to exploration of residential placement or facility-based services.
        ii. Service delivery includes paid and unpaid services and supports by waiver and/or other service providers (e.g., Medicaid State Plan providers, ADRS providers, special/general education provider, and generic community service providers), friends, family, and other natural support networks.
    b. Support Coordinators will assist people with maintaining eligibility for the waiver and provide education and support as needed.
    c. Assessment resources and procedures:
        i. Support Coordinators will utilize assessment and planning resources and procedures approved by DMH-DDD.
            1. Resources, procedures, and other training information are listed on the ADMH website: https://mh.alabama.gov/training/
        ii. Support Coordination Agencies will conduct assessments using person-centered and strength-based approaches including: involving the person in all assessment activities; exploration (with the person) of preferences and what works well for the person, identification of the person's own strengths and other positive attributes, and encouragement of self-determination and self-direction. (see SC Guideline Appendix 1)
        iii. Assessments will be completed with the person and, as applicable, their legally authorized representative, within 30 days of enrollment in the Waiver program and thereafter as appropriate to the person, but at least annually.
            1. Any identified initial health and safety concerns will be addressed within 14-days of waiver program enrollment.
        iv. Assessment documentation will include the person's desired outcomes, in their own words, and capture the exploration of hopes and dreams from the assessment conversation.
        v. Assessment documentation will include the agreed strategies to achieve the person's desired outcomes and meet the their assessed needs related to these outcomes that will appear on the person-centered plan noting how the strategies will be implemented (including in what settings the individual selected) by the person, natural support network, community supports, and paid services and supports.
        vi. Assessment documentation will include exploration and determination of back-up and contingency plans for situations where identified supports associated with the defined strategies are not available, and these back-up and contingency plans will appear on the person-centered plan.

vii. The Support Coordinator will use assessment information to create a draft person-centered plan.
    1. Support Coordinators will recognize all people possess unique abilities and attributes that contribute to the achievement of their goals and independence.
    2. Person-centered plans will document the strategies agreed upon by the person from the assessment process noting how the strategies will be supported by the individual, natural support network, community supports, and paid services and supports, along with the frequency of support, units of support, and cost per unit of support.
    3. Assessment and Person-Centered Planning will focus on the combination of the person's strengths, needs, and community of supports in determining strategies to compliment and assist in the attainment of goals for each person to live his/her best life, as defined by the person after exposure to all options and support for informed choice.
    4. Planning needs to address all person identified, desired outcomes incorporating strengths and capacities to build on and barriers to be overcome
    5. Planning will address Support Coordinator or other clinical professional identified risks associated with not utilizing/building on strengths, risks identified with not overcoming barriers to desired life and outcomes, and other risks that may be identified by the Support Coordinator or other clinical professionals.
    6. If a person does not agree or recognize one or more risks identified by the Support Coordinators or other clinical professionals, Support Coordinators will follow the Risk Management direction found in section 2.h of this policy.

viii. A Team Meeting will occur, including the person, and legal representative if applicable, to review, discuss and finalize all aspects of the Person-Centered Plan.
    1. Members of the Team, invited to the Team Meeting, will receive a copy of the draft person-centered plan before the Team Meeting.
    2. Person-centered plans will be finalized with the person and, as applicable their legally authorized representative within 60 days of enrollment in the Waiver program and thereafter updates as appropriate to the individual, but at least annually.

ix. The person-centered plan is a living document, therefore changes occurring within the review period will be updated in real time within the assessment and plan. Person-centered assessments and plans, and updates to the assessments and plans, will be signed, and dated by the person, their legally authorized representative, the provider(s) responsible for implementing strategies, and the Support Coordinator.

x. Signed completed person-centered assessments and plans will be sent to providers.

d. Re-assessment and Monitoring:
   i. Support Coordinators will assess and document progress as needed, but at least every 90 calendar days and document within the person-centered assessment/plan and progress notes. This includes a check-in with the provider and the person.
   ii. Support Coordinators will annually assess and document updates to the person-centered plan and assessment, minimally completing the re-assessment section in ADIDIS.

e. Back-up and contingency planning:
   i. Assessment and planning documentation will include back-up and contingency exploration for situations where supports of identified strategies are not available.
   ii. Support Coordinators will report lack of supports for a service to the appropriate Regional Office.
   iii. Support Coordinators will work with the appropriate Regional Office to build capacity for this service.
   iv. Support Coordinators will research existing providers and explore the possibility of providing the service to support the person.
   v. Support Coordinators will ensure a short-term plan of care is developed in accordance with person-centered planning practices to support individual's receiving temporary respite supports. The short-term plan will outline what goals will be achieved, what individual's preferences, strengths, and needs are, and their back-up plan.

f. Promotion and Protection of Individual Rights and preventing abuse of individuals:
   i. Support Coordinators will implement operational practices that promote and protect the rights of individuals as defined by all applicable Federal and State of Alabama regulations, laws, acts, and other legal authority.
   ii. Support Coordinators and the provider agency will participate in a discussion at the annual meeting to ensure people are informed of their rights. The Support Coordinator documents the conversation and provide a copy of the Rights & Responsibilities form to the provider agency.
   iii. Support Coordinators will work with providers and communities to ensure people have meaningful work and activity choices. These choices should encourage and promote age-appropriateness, a positive self-image, and consider the person's cultural background and/or preferences. 580-5-33-.05(13)
   iv. Support Coordinators will implement operational practices to ensure individuals receive only the level of support needed for the individual to make their own decisions, including assisting the individual to advocate for themselves.
   v. Support Coordinators will provide individuals and their legally authorized representatives an oral and written summary of their rights and responsibilities and how to exercise those rights and responsibilities.

vi. Support Coordinators will maintain practices for due process, including review and documentation, in the event of a proposed restriction of an individual's rights.
vii. Support Coordinators will provide education and/or resources on voter registration and the voting process to people age eighteen or older that express interest and assists with registering and voting, as needed.
viii. Support Coordinators obtain written informed consent from the individual or their legally authorized representative prior to
    1. any intrusive medical or behavioral intervention,
    2. participation in research, and
    3. sharing information about the individual
ix. Materials presented to individuals or their legally authorized representative is provided in language the individual can understand.
x. Support Coordinators provide individualized supports/services that are free from discrimination by race, gender, age, language, ethnicity, disability, religion, sexual orientation, or financial circumstances.

g. Fraud, waste, and abuse:
    i. Support Coordinators will comply with all provisions of Chapter 560-X-4.04 and Chapter 560-X.4.05.
    ii. Support Coordinators will monitor the person's financial situation and ensure individuals are not paying for anything covered by a waiver service.

h. Behavioral Support Plans:
    i. If appropriate, individuals have a Behavior Support Plan that reduces, replaces, or eliminates specific behaviors and are implement according to DMH-DDD's Behavioral Services Procedural Guidelines.
        1. Behavior Support Plans are created by the provider agency. The provider agency will submit a copy of the Behavior Support Plan to the Support Coordinator to be documented within the Person-Centered Assessment and Plan.
        2. Support Coordinator will document any restrictions or need for restraints in the Person-Centered Assessment and Plan
        3. Changes to the Behavior Support Plan are made and implemented by the provider agency with the agreement of all team members.
    ii. Behavior Support Plans are approved by the Support Team.
        4. Behavior Support Plans with level 2 or 3 procedures are reviewed and approved by the Behavior Review Committee, the Human Rights Committee, and the individual or individual's legally authorized representative.
    iii. Behavior Support Plans are reviewed at least quarterly, or more frequently as required by the individual's needs, for effectiveness and appropriateness.
    iv. Highly intrusive behavior interventions or punishment for the convenience of staff or in lieu of a Behavior Support Plan are not permitted.

i. Crisis planning and intervention:

i. Support Coordinators will follow the CSS Team operation guideline found in OG 7.3.

j. Risk Management:
   i. Every person has the right to make informed decisions of their choosing necessary for individual growth and development. Service Coordinators will support dignity of choice and risk, allowing for self-determination related to reasonable risks of personal choices.
   ii. The assessment, development, planning and implementation of risk mitigation strategies are discussed and agreed upon by all team members at the annual meeting.
   iii. Support Coordinators are responsible for:
      1. Identifying and evaluating potential positive and negative risks associated to choices made by the individual.
      2. Identifying the person's tolerance for accepting and taking that associated risk related to the person's goals and preferences.
      3. Development and communication of risk strategies for choices the person determines are worth accepting and taking.
      4. Identifying methods and processes to monitor the effectiveness, updates, and continued use of risk mitigation strategies.
      5. Documenting the risks identified and risk mitigation strategies for each person as part of the person-centered assessment and plan.

k. Natural Support Networks:
   i. Support Coordinators ensure there are a variety of methods for helping people stay connected to their natural supports.
   ii. Support Coordinators will work with provider agencies to identify strategies to meet the desired level of contact with natural supports identified during the person-centered planning conversations.
   iii. Support Coordinators ensure the person is provided education to develop and/or improve skills to support people's communication with natural supports, especially families and friends.

l. Conflict of interest:
   - Support Coordinators will avoid conflicts of interest that interfere with the timely and effective assessment, planning, and support of people enrolled in waiver programs.
   - At a minimum, Support Coordinators and provider agencies will adhere to the Conflict Free Support Coordination/Case Management Services outlined in Scope of Service section 2.1.

4. Collaboration: Support Coordinators will collaborate with service and agency providers to identify, assess, and implement person-centered plans and community resources to enhance service options, and document such within the Person-Centered Assessment and Plan.

a. Support Coordinators will maintain knowledge of applicable waiver service options, community resources, and a person's natural supports.

b. Support Coordinators will identify gaps in contracted service capacity for improvement and development.
c. Support Coordinators will address any environmental and safety concerns with provider agencies and ensure education is provided to the individual on how to mitigate any safety concerns.
d. Support Coordinators will share pertinent information regarding the individual's support needs, including medical care, safety concerns, etc. with all applicable Support Team members.
e. Support Coordinators will partner with paid and unpaid service providers to identify opportunities for innovative practices to implement person-centered planning.
f. Support Coordinators will monitor the implementation of person-centered plan strategies and partner with providers to improve effectiveness and address any training gaps.

5. **Documentation Best Practices: ** *Under Construction*

Appendix 1: For Self-Directed Support, the Support Coordinator is responsible for completing the assessment.

Current Form/ Process	Provider Responsibility	SC Responsibility
* Functional Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings for assistance with ADLs and IADLs within the barriers (core issues) section of each domain as appropriate within the PCP
Nursing Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Overall Health subsection of the Healthy Living Domain
*Financial Assessment or Money Management Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Finances subsection of the Community Living Domain
Fall Risk Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Safety subsection of the Community Living Domain
Behavior Support Plan	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the MH & AODA subsection of the Healthy Living Domain
Medication Reduction Plan or Psychotropic Medication Plan	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Medications subsection of the Healthy Living Domain
*Safety Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Safety subsection of the Community Living Domain
*Rights Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Exercising Rights subsection of the Self-Determined Domain
Key Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Access to Possessions subsection of the Community Domain
Lease Contract	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Living Situation subsection of the Community Living Domain
This list in not all-inclusive, provider agencies should continue to follow current approved administrative standards.		
*These documents are always required regardless of services received.		

4.9. Free Choice of Provider and Free Choice Provider Complaint/Grievance Process

Responsible Office: Support Coordination
Reference: ID/LAD HCBS Waivers
Effective: Historical Practice
Statement: The Alabama Department of Mental Health - Developmental Disabilities Division (DMH- DD) requires the use of a Free Choice of Provider (FCOP) as well as the FCOP Complaint/Grievance process. Purpose/Intent: The Free Choice of Provider process ensures that individual supported has the right to choose their provider or each of their services without coercion. In addition, the FCOP Complaint/Grievance process allows the individual the opportunity to report concerns or issues with the selected provider. ADMH-DDD requires the use of a Free Choice of Provider (FCOP) form as well as the FCOP Complaint/Grievance form. The FCOP format is required but may be edited to include the provider names who provide services/supports for the person. The Complaint/Grievance form may not be edited.
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions: FCOP (Free Choice of Provider), SC (Support Coordination)
Procedures:
Free Choice of Provider
Free Choice of Provider is a requirement that must be ensured throughout the delivery of HCBS Waiver Services. Individuals receiving services must have the opportunity to choose their direct support provider and where there are multiple support coordination providers, individuals must receive choice among them.
The Support Coordinator must:

- Ensure the FCOP must be completed at the time of new admission, annually and every time the person supported changes provider.
- Ensure the choice is as informed as possible by the offer to the person supported to arrange a visit with any provider at any time the person desires
- Must be impartial as to choose made by the person supported and may never steer or otherwise influence the person's decision
- Ensure the document is completed and signed. SC may sign as a witness.
- Offer a copy of the signed document to anyone who signs the document.
- Scan the signed form into the notes of ADIDIS as a part of the redetermination packet and at the point that there is a provider change.
- Maintain the original in a secure location as this completed form is subject to review by Alabama Medicaid and Alabama Department of Mental Health auditors

Free Choice of Provider Complaint/Grievance Process
The Support Coordinator must:

- Review with the person supported and the legally authorized representative the FCOP complaint/grievance process. In the absence of a legally authorized representative and when the person permits, it should be reviewed with the responsible family member.
- Point out that although they can call any of the phone numbers listed, their call will likely be rerouted to the Region for their county of residence.

- Provide the person a copy of the form so they will have the phone numbers readily available
- Provide the approved, non-personalized by county form (located on the ADMH website)

CHAPTER 5
PROVIDER REQUIREMENTS AND OTHER INFORMATION

5.1. New Provider Enrollment

Responsible Office: Office of Quality and Planning/Certification
Reference: ADMH Administrative Code 580-3-23-.09 Certification of Community Programs; ADMH Policy 540-003, 550-001; 580-3-25 Administrative Review for the Certification of Community Programs; 580-5-30 Intellectual Disabilities Services
Statement: completion of the New Provider orientation, the prospective provider will have all the necessary information required to complete and submit an application seeking approval to become a provider of services and supports.
Purpose/Intent: To provide a step by step process to Prospective Providers of becoming a certified provider of DD services and supports.
Scope: Office of Quality and Planning, Prospective Community Providers, Office of Certification Administration, Regional Community Service Offices and Fiscal Office.
Procedures:
Phase ONE - Overview

1. Prospective provider completes online training

Phase TWO – Orientation (capacity 50)

1. Prospective provider attends live event session
    a. Morning session covers general information
    b. Afternoon session covers DD specific information
        - Application package received after sign-in and contents reviewed
        - PowerPoints presented
            - HCBS Settings Rule requirements (PowerPoint)
            - Regional Office Locations
            - Services available to provide
            - Application Process
            - Provider requirements overview
            - Managed funds
            - Organization's Name
        - Questions answered
2. Prospective provider MUST complete entire orientation to continue process
3. Prospective provider completes application and submits it to ADMH Office of Certification Administration (OCA)
4. Prospective provider must submit application package within 1 year of attending orientation
5. OCA submits background check to Bureau of Special Investigation (BSI)
6. BSI forwards completed background check to OCA
7. OCA forwards application package w/background check to the Office of Certification
    a. If BSI reports prospective provider meets requirements, application moves to next step

b. If BSI reports prospective provider does not meet requirements, application package is denied, and a notification is sent to applicant

8. Application package is reviewed by the Office of Certification. **All supporting documentation from the following checklist must be submitted with the application.**

ALABAMA DEPARTMENT OF MENTAL HEALTH DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES CERTIFICATION APPLICATION AND SUPPORTING DOCUMENTATION

SERVICES TO BE PROVIDED TO TARGETED POPULATION

Use the letters and numbers below to complete the chart below. For example, if you propose to have Residential Services for men and women, put C in the Gender Served column, 1, 2, or 3 in the Age Group column, and the total number of people in the Number to be Served column.

Gender Served	**Age Group**
A = Male	1 = Children (4-12)
B = Female	2 = Adolescents (13-20)
C = Both	3= Adults (21+)

Services to be Provided	**Gender Served**	**Age Group Served**	**Number to be Served**
Supported Employment Services			
Hourly Services-Personal Care or Respite			
Day Habilitation			
Other (specify)			

BACKGROUND INFORMATION

1. Have you, your corporation or any other businesses owned/operated by you, or the business entity that is the subject of this application ever been the subject of any investigation for fraud or false claims related to Medicaid or any other state or federal program, or have you, your corporation, or any other businesses owned/operated by you, or the business entity you now represent ever been found in either an administrative or judicial proceeding to be guilty of fraud or false claims in conjunction with Medicaid or any other state or federal program?

_____Yes _____No

If yes, please provide a complete explanation (attach separate page if necessary) of the allegations, proceedings if any, and disposition if any.

2. Have you, your corporation or any other businesses owned/operated by you, or the business entity that is the subject of the application, or any business entity in which you have an ownership or control interest* ever had an application for certification denied by the Alabama Department of Mental Health (ADMH) or by any other state or federal licensing/certification authority , or having been certified or licensed by any such authority, have you, your corporation

of any other business owned/operated by you, or the business entity that is the subject of this application, ever had a license/certification revoked or been decertified by the Alabama DMH/MR or by any other state or federal licensing/ certification authority.

_____Yes _____No

If yes, please provide a complete explanation (attach separate page if necessary) of the circumstances surrounding the denial, revocation or decertification and the final disposition of the same.

*An individual is considered to have an ownership or control interest in a provider entity if he has direct or indirect ownership of 5 percent or more, or is a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity as defined in under 42 CFR section 1001.1001(a) (1).

DOCUMENTS TO BE INCLUDED WITH APPLICATION

1. _____ Copy of diploma as proof of degree (Executive Director/Owner/Operator)
2. _____ 5 years' experience with service provision to ID population in detail (Executive Director/Owner/Operator)
3. _____ Articles of Incorporation/Articles of Organization
4. _____ Board Bylaws/ LLC Operating Agreement
5. _____ Board/Executive Committee minutes for the past year
6. _____ Documentation indicating at least a 90-day cash reserve for operations
7. _____ Fiscal Policy (Organizational Fiscal Practices. Covers at least accounting guidelines, risk control, financial planning, financial reporting, revenue and expenditures, and asset management.)
8. _____ Operational Budget
9. _____ Organizational Chart
10. _____ Curriculum vitae (resume) of executive director
11. _____ Description of primary geographic area to be served
12. _____ Copy of the program policies and procedures
13. _____ Quality Improvement Plan
14. _____ Copy of individual rights policies and procedures
15. _____ Emergency Crisis Response Plan
16. _____ Written Description of each program for which certification is requested
17. _____ Vitae (resume) of Clinical Director, Program Coordinators, Directors, Supervisors, Qualified Intellectual Disabilities Professional (QIDP)
18. _____ Copy of staff training required prior to staff working with individual receiving services
19. _____ Copy of staffing pattern for services to be provided
20. _____ Prospective Provider Certificate of Attendance

Untruthful/fraudulent information may be cause for denial of an application. No future applications will be considered.

If you are a currently certified entity submitting an application for a new sub-contractor, you must submit all items listed above.

If you are currently certified as a sub-contractor and wish to be an independently certified entity you must submit all items listed above.

9. If application package does not meet criteria, package is either returned to applicant for additional information or denied and returned to applicant. Reasons for not approving applications:
    a. Unfavorable background check for Executive Director (ED) (can reapply with new ED)
    b. Falsification of information (cannot apply again)
    c. Lack of educational background for Executive Director (can reapply with new ED)
    d. Lack of required experience (5 yrs.) for Executive Director (can reapply with new ED)
    e. Application reviewed 3 times
    f. Pattern of substantiated incidents of abuse, neglect, mistreatment, and exploitation
    g. Setting does not meet HCBS Settings Rule
    h. Presence on the Exclusion List
    i. Agency has demonstrated an inability to take on added responsibility of additional setting or service (can reapply after next favorable full review)
        - Provisional Certification
        - Extended TOA (s)
    j. Previously Decertified
    k. Inappropriate name for organization (can reapply with favorable name)
10. If application package meets criteria, application is approved and sent to OCA for issuance of a Temporary Operating Authority to provide services
11. OCA notifies applicant of approval and TOA issuance and requests $1,500 application fee. Once application fee is received by OCA, OCA notifies Office of Certification and Regional Office of new provider status

Phase THREE – *Selection of "Setting"*

1. Provider submits application for 'proposed' setting location to OCA
2. OCA forwards the application to the Office of Quality and Planning (OQP) for review and recommendation.
3. OQP returns the application with the Application and Setting Review Form (Exhibit 5.1.), with recommendation and any supporting documentation for all new settings, to the OCA.
4. The OQP completes part 1A and 1B. If question 1A or 1B of the form is "Yes", the application is not approved and will not be processed further. If questions 1A and 1B are "No", the OCA forwards application and form to the Regional Community Services (RCS) Office for review and recommendation.

5. RCS completes Part B and returns the application with form and any supporting documentation to the OCA who forwards to the OQP for final review. The OQP reviews application and supporting documentation.
    a. Approved for Certification: If for a new setting, the application is approved for a 6-month TOA following the Life Safety inspection and is returned to the OCA.
    b. Approved for Certification: If for a new service, the application is approved for a 6-month TOA and is returned to the OCA. Life safety is not required.
    c. Not Approved for Certification: If for a new setting or new service, the application is not approved and a letter detailing the denial is returned to the OCA.
6. Life Safety completes a review.
    a. Setting passes: Life Safety review, documentation/application returned to OCA.
    b. Setting does not pass: Provider given opportunity to correct deficiencies, if possible, or can opt to acquire another property. If provider chooses to acquire new property, process starts over. Documentation/application returned to OCA.
7. OCA notifies Alabama Medicaid Agency (AMA), Office of Certification, and Associate Commissioner of the TOA.
8. Office of Certification assigns a setting number and notifies Office of Systems Management (OSM), and
   Regional Office.
9. Regional Office notifies appropriate 310 Authority for Targeted Support Coordination (TSC) so the provider can be placed, as an option, on the Free Choice of Provider List.
10. Regional Office Fiscal Staff initiates contract process and establishes a $1.00 place holder contract.

If no services are provided in the setting at the end of the 6-month certification date, the TOA must be renewed.

Phase FOUR – *New Provider Orientation*

1. Overview of ID Services
    a. Scope of Waiver
    b. HCBS
    c. Operational Guidelines Manual
    d. Funding and Maintaining Eligibility
    e. Waiting List/Placement
    f. Supported Employment
    g. Housing
    h. Community Integration
2. Fiscal Management
    a. Contract Process
    b. Billing and Claims
    c. IRBI
3. Community Services
    a. Provider Self-Assessments
    b. Validation/Monitoring/POA Process

c. Special Team Meeting
d. IPMS
e. Nursing
f. Regional Technical Assistance

4. Comprehensive Support Services
    a. Behavioral Support Planning
    b. Crisis Management
5. Certification
    a. Administrative Code
    b. Certification Overview
    c. HIPPA
    d. Person-Centered Planning
6. Quality Enhancement
    a. Person-Centered Thinking
    b. Fatal Five
    c. Basic Assurances (Factor 10 Training)
    d. 4-Day POM Training
7. Support Coordination
    a. Case Management/Support Coordinator Training
    b. Role of Support Coordinator
    c. Choice Process
    d. Overview of Functional Assessments
    e. Person Centered Planning Facilitation
    f. Plan of Care
8. Advocacy & Rights Protection
    a. Rights Training/Assessment
9. Nurse Delegation Program
    a. Alabama Board of Nursing Data Collection
    b. MAS Nursing
    c. Level 2 & 3 Medication Error Forms
    d. NDP Certification Score Sheet

Phase FIVE – *Initiation of service to Medicaid Beneficiary*

1. Medicaid beneficiary notifies TCM of choice of new provider
2. Packet is completed to include Provider Agreement and Provider Disclosure and sent to OSM
3. OSM forwards packet to AMA
4. AMA performs fraud review and if none, issues a Provider Number
5. SM enrolls provider in DDD IMS
6. Provider bills to date of Medicaid beneficiary's beginning service date

Phase SIX – *HCBS Settings Rule Compliance (MUST MEET 100% COMPLIANCE)*

1. Provider should have met all HCBS Settings Rule criteria except for the Individual Experience Assessment prior to Medicaid beneficiary's service date

2. After transition occurs, the Individual Support Coordinator's first three monthly contacts occurs face-to-face. One visit will occur within 55-65 days to complete the Individual Experience Assessment (IEA).
3. The IEA must be completed by Support Coordination Services (SCS) between 55-65 days and make needed adjustments to the Medicaid beneficiary's Person-Centered Plan (PCP) as appropriate. SCS should provide a copy of the IEA to the provider's Regional Office (RO) Monitor for HCBS Settings Compliance review. The RO monitor completes validation within 60 days of the provider completing the (HCBS) self-assessment. The provider then has 30 days to make corrections that meet expectations for 100% compliance
4. At 90 days, if provider does not meet 100% compliance with the HCBS Settings Rule, the TOA is withdrawn, and Emergency facilitation of CHOICE meetings begin
5. At 90 days, if provider meets 100% compliance with the HCBS Settings Rule, the TOA remains in good standing
6. Certification completes a review of the TOA setting before the end date of the 6-month certification
    a. For new provider, full review is conducted once an individual has been admitted before the end of the TOA
7. For established provider, a review of the TOA setting is conducted once an individual has been admitted before the end of the TOA certification date. If all qualifications are met, the setting is aligned with the agency's certification date.
8. HCBS Settings Rule compliance monitoring continues with 6-month monitoring visits

5.2. Temporary Operating Authority (TOA) Process

Responsible Office: Office of Quality and Planning/Certification
Reference: ADMH Administrative Code 580-3-23-.08 (1) & (7); ADMH Policy 550-001
Revised: September 17, 2020
Statement: Once a provider's application is approved for a new setting or new service, the program is issued a letter of Temporary Operating Authority by the DMH/DD Commissioner allowing it to operate for a period up to 6 months.
Purpose/Intent: To provide providers with the TOA process.
Scope: Support Coordinator Services; ADMH-DDD Central/Regional Offices
Procedures:

1. The provider submits an application for a new setting or service (Exhibit 5.1.) to the Office of Certification Administration (OCA).
2. The OCA logs application pack and criminal background check notification from BSI.
3. The OCA forwards the application to the Office of Quality and Planning (OQP) for review and recommendation.
4. OQP returns the application with the Application and Setting Review Form, with recommendation and any supporting documentation for all new settings, to the OCA.
5. The OQP completes part 1A and 1B. If question 1A or 1B of the form is "Yes", the application is not approved and will not be processed further. If questions 1A and 1B are "No", the OCA forwards application and form to the Regional Community Services (RCS) Office for review and recommendation.
6. RCS completes Part B and returns the application with form and any supporting documentation to the OCA who forwards to the OQP for final review. The OQP reviews application and supporting documentation.
    a. Approved for Certification: If for a new setting, the application is approved for a 6-month TOA following the Life Safety inspection and is returned to the OCA.
    b. Approved for Certification: If for a new service, the application is approved for a 6-month TOA and is returned to the OCA. Life safety is not required.
    c. Not Approved for Certification: If for a new setting or new service, the application is not approved and a letter detailing the denial is returned to the OCA.
7. For a new setting, the OCA forwards requirement to Life Safety inspection for scheduling.
    a. Life Safety completes a review.
        i. Setting passes: Life Safety review, documentation/application returned to OCA.
        ii. Setting does not pass: Provider given opportunity to correct deficiencies, if possible, or can opt to acquire another property. If provider chooses to acquire new property, process starts over. Documentation/application returned to OCA.
    b. The OCA prepares a letter of TOA for new setting and new service for the Commissioner's signature.
    c. The OCA sends TOA to provider, OQP, and Medicaid.
    d. The OQP notifies RCS and the Central Office Application Support Specialist of the TOA and provides a new setting/new service number.
    e. Prior to expiration of the TOA, if there are no people receiving services in the setting, the provider must resubmit another application to the OCA.

5.2.a. Certification Status and Adding New Settings, Services, and/or Individuals

Responsible Office: Office of Quality and Planning/Certification
Reference: Chapter 580-1-4 covers Administrative Standards for Providers (non-310)
Revised: May 28, 2021
Statement: This process is a guide for community providers wanting to add new settings, new services, and/or individuals.
Purpose/Intent: To provide community providers with the process for adding new settings, new services, and/or individuals and the requirements relating to certification status.
Scope: DDD HCBS Waiver Providers; Support Coordinator Services; ADMH-DD Central/Regional Offices
Definitions:

- Contractor: any entity having a direct contract with the Alabama Department of Mental Health (ADMH)Division of Developmental Disabilities (DDD) to provide Home and Community Based Services (HCBS) waiver services. The Contractor is responsible for Quality performance of ALL of its subcontractors, regardless of the type of agreement with the subcontractor. The Contractor must establish a continuous quality improvement (CQI) system, which complies with the standards set forth by the ADMH that includes ALL of its sub-contractors
- Subcontractor: any entity that enters into an agreement or contract with an Agency that directly contracts with ADMH-DDD to provide HCBS waiver services
- Standalone subcontractor: a sub-contractor who contracts with a contractor for waiver claims billing only. A Standalone subcontractor must be designated as such and must be certified to provide HCBS waiver services
- OCA – Office of Certification and Administration

Procedures:
When the provider's provisional status is removed, ADMH-DDD will only approve a 'replacement' setting if it meets all normal requirements (approval by OCA, Office of Quality and Planning and Life Safety) for a setting's approval. 'New' settings will not be approved until the provider completes two successful certifications (see below). Please note, Regional Offices do not make the final determination on whether a setting is approved. Final determination on whether a setting is approved is made by the Office of Certification in Montgomery. They should, however, confirm the provider is in the appropriate certification status in order to add new settings, new services, and/or receive individuals to serve prior to visiting a proposed setting and/or referring someone to a setting for services.

NOTE: When a provider is in provisional status, said provider cannot be referred individuals to serve nor accept new individuals, add a new setting nor new service. Once provisional status is removed, they may receive referrals to serve and accept new individuals into a setting.

ADMH-DDD will not approve additional settings or services, following a provisional certification, until the provider successfully completes two regular (Full programmatic) certification reviews. The certification process, once a provider receives provisional status, is as follows:

1. Regional Offices MUST verify the provider is in good standing and can accept referrals for individuals to be served.

2. Regional Offices MUST verify the provider is in good standing before visiting any proposed new setting.
3. Provider receives provisional status for deficiencies noted during their regular/full programmatic certification review.
4. Within 60 days of the review, a certification follow-up is provided to determine if the provisional status should be removed. NOTE: ONLY deficiencies cited during the previous regular/full certification review that warranted the provisional status will be reviewed during 60-day follow-up.
5. If the deficiencies are determined corrected during the 60-day follow up, the provisional is removed and a regular/full certification review is scheduled one year from the regular certification date.
6. If the deficiencies are determined not to be corrected during the 60-day follow up, the provisional is extended another 60 days and another follow up is scheduled.
7. If the second follow-up determines deficiencies remain, depending on the severity the deficiencies, the provisional can be extended or the provider may be recommended for decertification.
8. NOTE: Additional extensions may be granted depending on the nature of the deficiencies and the provider's progress towards successfully addressing the deficiencies. DMH Staff must ensure technical assistance is provided to assist the provider to resolve deficiencies. Mandated technical assistance is warranted any time deficiencies are related to Health, Safety and Abuse, Neglect, Mistreatment, and Exploitation.
9. If the follow-up determines all deficiencies are corrected, the provisional status is removed, and the provider must achieve successful certification in TWO REGULAR (full program) certification reviews according to the Office of Certification and Administration's (OCA) two-year certification cycle.
10. A one- or two-year certification following a provisional status is based on the provider's certification score AND the OCA's certification cycle.

EXAMPLE OF CERTIFICATION WITH PROVISIONAL:
Contractor (with or without subcontractors (excluding standalone subcontractor) receiving TWO successful
regular reviews following a Provisional certification:

- Provider received provisional April 2018 after a regular certification review.
- The provider came off provisional in June 2018 and received a one-year certification. The provider will need TWO regular/full reviews before they, or their sub-contractors (excluding standalone sub-contractors) can add new settings.
- April 2019 – the provider successfully achieved a review that did not place them in provisional status. This successful review will be considered the FIRST of TWO regular, successful certifications following a provisional status.
- April 2020 – the provider successfully achieved a review that did not place them in provisional status. This certification review is the SECOND regular full review with no deficiencies noted that would place them in a provisional status. After this SECOND successful regular review, the contractor will receive a 1- or 2-year certification based on their certification score and OCA's certification schedule the provider is now approved to request new settings.

Contract and/or Standalone Subcontractor receiving one successful review following a provisional, then

another provisional, followed by two successful regular reviews:

- Oct 2017 a provisional status was given due to deficiencies; Deficiencies were corrected by 60 day follow up and provisional was removed in Feb 2019. A 1-year certification was granted
- Oct 2018 a regular/full certification is provided, and no deficiencies are noted that warrant a provisional status, this review will count as the FIRST certification granted after provisional status and they will receive a 1- or 2-year certification based on their certification score and OCA's certification schedule.
- Oct 2019 a provisional status was given due to deficiencies; Deficiencies were corrected by 60 day follow up and provisional was removed in Feb 2019. A 1-year certification was granted
- Oct 2020 – the provider successfully achieved a review that did not place them in provisional status. This successful review will be considered the FIRST of TWO regular, successful certifications following a provisional status and the contractor/standalone provider will receive a 1- or 2-year certification based on their certification score and OCA's certification schedule
- Oct 2021 – the provider successfully achieved a review that did not place them in provisional status. This certification review is the SECOND regular full review with no deficiencies noted that would place them in a provisional status. After this SECOND successful regular review, the contractor/standalone provider will receive a 1- or 2-year certification based on their certification score and OCA's certification schedule, the provider is now approved to request new settings.

5.3. New Provider Enrollment with Alabama Medicaid Agency

Responsible Office: System Management
Reference: Administrative Code 580-5-30-.13; Alabama Medicaid Provider Manual, OG# 4.1
Statement: New Providers will be enrolled with the Alabama Medicaid Agency's Fiscal Management Payment System (FMPS)
Purpose/Intent: To ensure new providers are enrolled as required to submit claims data and receive payment for service provision
Scope: For all new providers
Definitions: DDD IMS (Division of Development Disabilities Information Management System)
Procedures: Once a new provider has been certified or receives a temporary operating authority (TOA), notification is sent to the appropriate regional office.

1. The Regional office provides enrollment forms that include:
    a. The Provider Agreement
    b. Disclosure Form
2. Providers complete the required forms and return the originals to the Regional Office for review before forwarding to the DD Central Office Application Support Specialist.
3. The Application Support Specialist reviews the forms further and collects any required missing information.
4. Contract site is monitored for indications of a fully executed contract
5. Upon contract completion, the Enrollment Packet is finalized and sent to AMA Fiscal Management Payment Interchange System for enrollment. Enrollment Packets include the following forms:
    a. ADMH Provider Agreement(s)
    b. Disclosure Form(s)
    c. FMPS Enrollment form for appropriate waiver(s)
6. Interchange is monitored for completion of enrollment and assignment of the Medicaid provider number.
7. When a Medicaid Provider number is assigned, the provider is added to the DDD IMS sites (TEST and LIVE).
8. The Regional Office Fiscal Officer notified the process of enrollment is completed.

5.4. Validation of Provider HCBS Self-Assessment

Responsible Office: Regional Community Services
Reference: ADMH DDD Residential Setting Self-Assessment; ADMH DDD Non-Residential Setting Self-Assessment; ADMH DDD Benchmark Guide for Adult Residential Programs; ADMH DDD Benchmark Guide for Adult Non- Residential Programs
Revised: February 11, 2020
Statement: The Regional Community Services staff will validate provider responses to the Residential and Non- Residential HCBS Self-Assessments.
Purpose/Intent: The validation process will ensure setting adherence to the HCBS Settings Rule and will involve communication between the Regional Monitor, the provider, and the Community Services Director, with findings shared with the Director of Planning and Quality Enhancement.
Definitions: HCBS (Home and Community Based Services); DDD IMS (Division of Developmental Disabilities Information Management System); CSD (Community Services Director); QE (Quality Enhancement)
Procedures:

1. Regional Monitors will review the HCBS Self-Assessment Tool for the assigned setting in DDD IMS.
    a. If the HCBS Self-Assessment is incomplete or is not submitted by a Provider:
        i. On May 15, 2019, the Provider will be notified in writing of the need to immediately complete and submit the Self-Assessment.
        ii. If no HCBS Self-Assessment is submitted by May 31, 2019, a second letter will be generated for the Provider, outlining the contractual consequences of failure to comply with the Self- Assessment mandate.
        iii. If no HCBS Self-Assessment is submitted by August 31, 2019, the assigned Regional Monitor will, by September 30, 2019, conduct a routine monitoring visit, for the purpose of ensuring basic health, safety and security, as per the previously established monitoring process.
2. Regional Monitors will schedule a visit to the assigned setting with a 7-day advance notice to the Provider.
3. Regional Monitors will make all necessary arrangements with the Provider to:
    a. Review the required documentation that supports the Self-Assessment.
    b. Meet with and interview (at the site) those receiving services there, as well as an employee of the Provider agency knowledgeable of the information required to complete the Validation Tool.
        i. For Non-Residential settings, a minimum of 10% of Person-Centered Plans (PCP's) and associated documentation must be reviewed.
        ii. For Residential settings, 100% of Person-Centered Plans (PCP's) and associated documentation must be reviewed.
4. Regional Monitors will complete the visit, enter the validation review into DDD IMS, including findings requiring Provider action into the Setting Transition-to-Compliance Plan, and provide a copy of the report to the Provider within 10 days.

5. The Provider will have 15 business days to complete the Setting Transition-to-Compliance Plan, providing methods and timeframes for resolving all validation findings for the setting demonstrating non-compliance or partial compliance with the HCBS Settings Rule.
    a. During a validation visit by the Regional Monitor, any incidental findings that directly impact rights, restrictions, health, safety and/or security of persons served must be resolved by the Provider in advance of submission of the Setting Transition-to-Compliance Plan and submitted separately to the Monitor by email, to include date and method of resolution, along with accompanying substantiating documentation.
    b. Upon receipt, the Regional Monitor reviews the Setting Transition-to-Compliance Plan to ensure that it adequately addresses all validation findings and then submits it to the CSD/designee.
        i. If the Setting Transition-to-Compliance Plan does not address all validation findings or does so inadequately, the Regional Monitor provides that feedback to the Provider via email within 15 business days, copying the Community Services Director (CSD)/designee.
        ii. The Provider then has 10 business days from the date this feedback is delivered to correct the plan and re-submit.
        iii. The Regional Monitor will contact the Provider about the revised plan within 15 business days.
    c. If the Provider comprehensively resolves some validation findings prior to submission of the Transition-to-Compliance Plan, these findings are still to be included in the Setting Transition-to- Compliance Plan with date and method of resolution, along with accompanying substantiating documentation.
    d. If the Setting Transition-to-Compliance Plan is not submitted, the Regional Monitor will inform the Community Services Director/designee on the 16th day, and the CSD/designee will contact the Provider immediately to request submission.
    e. In the event the Setting Transition-to-Compliance Plan is not submitted, OR documentation requested to substantiate specific compliance is needed for DDD approval and there has been no response from the provider, a certified letter informing the provider of the unresolved items and the need for additional substantiating information will be mailed quarterly until 6/30/22.
    f. Once the Setting Transition-to-Compliance Plan is received and deemed complete by the Regional Monitor, they will notify the CSD/designee that it is available for review.
6. The CSD/designee will review/approve the Provider Transition-to-Compliance Plan within 7 business days of receipt of the completed plan.
    a. If the Setting Transition-to-Compliance Plan is not submitted within specified timeframes or is not accepted upon resubmission, the Regional Office will require the Provider to participate in assigned Technical Assistance pertinent to the identified area(s) of concern.
    b. The Provider will be given 30 days to complete the Technical Assistance and re-submit the Setting Transition-to-Compliance Plan.
7. The Regional Office will meet with all Regional Monitors (to include QE, Certification, or any regional office staff) at least monthly, to discuss the Setting Transition-to-Compliance Plans, so

as to identify Providers demonstrating difficulty transitioning to HCBS compliance, note cross-Provider trends in compliance, identify areas of needed technical assistance, etc.

8. The Regional Office will collect data on each setting's compliance with each part of the rule as evidenced by the Setting Transition-to-Compliance Plans and progress made on resolving each of the findings identified and provide monthly reports of such to the Director of Planning and Quality Enhancement for those settings completed during that particular month.
9. The CSD/designee will coordinate Technical Assistance with the Provider, to be completed by corresponding DMH staff, as assigned.
10. After completion of the validation review, the Regional Monitor will follow the same process within six months to review the assigned setting again and review specific progress achieved or not achieved with regard to the approved Setting Transition-to-Compliance Plan.
11. Thereafter, and until September 30, 2021, the Regional Monitor will twice annually utilize an HCBS Validation Check List during routine monitoring to ensure that the Provider remains in compliance with the HCBS Settings Rule.

5.5. Monitoring of Waiver Services

Responsible Office: Regional Community Services
Reference: ADMH Administrative Code 580-3-23-.13 through 580-3-23-.15
Statement: Regional Community Services (RCS) staff in each Fiscal Region observe and assess provision of Waiver services (Residential, Day and Supports) twice annually.
Purpose/Intent: Waiver services (Residential, Day and Supports) are monitored twice annually to ensure they are administered according to CMS and ADMH standards.
Scope: Regional Community Services; Director of Community Program
Definitions: CMS (Centers for Medicare and Medicaid Standards); RCS (Regional Community Services); CSD (Community Services Director); POA (Plan of Action); DDD (Division of Developmental Disabilities)
Procedures:

1. The Regional Monitor monitors every certified DMH/DD setting twice annually, once each during periods April 1 – September 30 and October 1 – March 31.
2. The Regional Monitor arrives to the setting unannounced, if possible. In the event two unannounced visits are attempted at disparate times, but no one is available at the setting, the Regional Monitor may contact the Provider directly to arrange a time when Waiver-served persons and Provider staff members will be present.
3. The Regional Monitor uses the corresponding Monitoring Tool (e.g., Residential, Day, or Supports) to complete the monitoring assignment, comprehensively addressing each item included and verifying with direct observation of substantiating documentation, interviews, and/or visual inspection, as appropriate.
4. In the event the monitoring visit yields findings that indicate immediate risks to health, safety or security, the Regional Monitor will immediately notify the Community Services Director (CSD) for determination of a safe and appropriate time frame for addressing the emergent finding(s) (e.g., 24 hours, immediately, etc.). It may be that the persons served at the setting should be temporarily relocated while the emergent findings are rectified. The Regional Monitor will then notify the Provider director/supervisor of the time frame for addressing the emergent findings and whether the persons served at the setting must be relocated until they are addressed.
5. The Regional Monitor completes the monitoring report and transmits to the Provider via email within ten (10) business days, delineating those findings requiring follow-up. The CSD/designee is to be copied on this email.
6. If the Provider receives a monitoring report that requires follow-up response(s), the Provider must address those findings and respond directly to the Regional Monitor within ten (10) business days with evidence of resolution for each.
    a. Note that any emergent findings that were resolved during or before that 10-day period must be reflected in the Provider's response as resolved.
    b. If there are findings that require more than 10 business days to resolve, the Provider is required to submit to RCS within the allotted 10 business days a Plan of Action (POA) for those findings, to include method and specific time frame of resolution.
7. If there are no findings requiring follow-up, or when all findings are fully and satisfactorily addressed, the Regional Monitor provides the closed monitoring report and, as applicable, substantiating documentation/evidence to the CSD/designee for review and notation of completion.

8. If the Provider does not satisfactorily address all findings within the allotted 10 business days, or if the POA submitted for any outstanding items is inadequate, inappropriate, or not satisfactorily resolved within the Provider's specified time frame(s), the Regional Monitor transmits a single prompt to the Provider on the eleventh business day after they were notified of the findings, with detailed explanation(s) and requesting final resolution. The CSD/designee is to be copied on this email.
    a. If the Provider does not respond to this prompt within five (5) business days, the Regional Monitor will notify the CSD and designee (if applicable) on the sixth business day.
    b. The CSD will meet with the designee (if applicable) and the Regional Monitor to review the unresolved findings and to identify appropriate topics of Technical Assistance for the Provider.
    c. The Regional Office will require the Provider to participate in the assigned Technical Assistance and then resolve the outstanding findings/provide substantiating evidence within 30 days.
    d. If the Provider does not satisfactorily resolve all findings following provision of Technical Assistance, the provider's initial Monitoring Report and POA (if applicable) will be reviewed by the CSD for recommendation of a "For Cause Review" by DMH certification.
9. If a "For Cause Review" is warranted by DDD Certification, the provider will be placed on Provisional status. At this time, the provider will be required to follow the procedures specified in ADMH Administrative Code 580-3-23-.13 through 580-3-23-.15.
10. For accountability purposes, the CSD/designee maintains a database of expected and actual Provider response/POA receipt dates.

5.6. Monitoring of Special Staffing

Responsible Office: Regional Community Services
Statement: Special staffing is a restriction that will be monitored for proper implementation.
Purpose/Intent: Regional Community Services staff will maintain current records of special staffing for each Fiscal Region and ensure that staffing at Residential and Day sites is implemented as required for each individual restricted with special staffing.
Scope: Regional Community Services; Fiscal Manager
Definitions: RFA (Request for Action); Community Services Specialist (CSS); GER (General Event Report); Community Services Director (CSD); Regional Community Services (RCS); Comprehensive Support Services Team (CSST); Behavior Support Plan (BSP); Individualized Residential Budgeting Instrument (IRBI)
Procedures:

1. The Behavioral and Psychological Evaluator maintains a comprehensive list of each Waiver-served person restricted with special staffing, whether for behavioral or medical reasons. This list includes the name of the Residential or Day provider responsible for the special staffing, as well as the physical address of the setting, the required staffing ratio (e.g., 1:1, 2:1, etc.), and the dates of approval and expiration of the special staffing restriction.
2. The Behavioral and Psychological Evaluator updates the special staffing list weekly, as special staffing for various persons is approved, terminated, or changed via the RFA process, and distributes the list via email to all RCS staff members for their reference.
3. RCS staff members assigned to monitor Residential and Day settings use the special staffing list to verify that the staffing provided on-site is consistent with what is required according to the updated special staffing list.
4. In the event staffing is not provided as documented according to the special staffing list, the Regional Monitor:
    a. Contacts the director of the provider agency (or an assigned supervisor) to ensure that the required staffing is provided as soon as possible.
    b. Directs the provider to complete a GER for this occasion of Neglect and submits via the Therap system.
    c. Notifies the Community Services Director (CSD) and the corresponding Incident Manager.
    d. The Incident Manager:
        i. Makes notification of the Neglect allegation to the person served and their guardian/family, as well as to the assigned support coordinator and Advocacy.
        ii. Requests a plan of correction from the provider, to be delivered within ten (10) business days.
    e. The CSD:
        i. Implements enhanced monitoring at the site, to a minimum of one visit per week by multiple RCS staff members for at least six (6) weeks. This enhanced monitoring is to include direct follow-up on the provider's plan of correction, required in 4.d.ii., above.
5. A second occasion of Neglect for inadequate staffing during the 6-week enhanced monitoring period will result in:

a. A recommendation of Provisional status for the provider to the Commissioner of Mental Health.
b. Immediate implementation of the choice process (with emergency temporary alternative placement, if necessary) to identify a new provider for the person. RCS staff must be present at the choice meeting.

6. If the special staffing restriction is not managed according to established and required standards (e.g., inadequate training of alternative behaviors; inadequate/inappropriate fading plan, etc.), the Behavioral and Psychological Evaluator will immediately notify the provider of those specific aspects that remain out of compliance and provide notice of a 30-day time frame to finalize and implement corrections.
    a. In the event that the necessary corrections remain incomplete and/or unimplemented after 30 days, the Behavioral and Psychological Evaluator will:
        i. Complete and submit a temporary IRBI for the person to Fiscal Management that reduces the daily Residential reimbursement rate to a typical, base (e.g., non-1:1, non-2:1) staffing rate;
        ii. Refer the provider to the CSST for technical assistance; and,
        iii. Require a plan of correction from the provider (within ten (10) business days) to address their timely and compliant handling of restrictions.
    b. If the provider's handling of the special staffing restriction(s) remains out of compliance after 30 days of implementing their plan of correction and receiving technical assistance, or if they refuse technical assistance or provide no plan of correction, as required in 6.a., above:
        i. The Incident Manager will complete a GER for Neglect and make notifications to the person served and their guardian/family, as well as to the assigned support coordinator and Advocacy;
        ii. CSST will assume direct management of the BSP and associated special staffing restriction;
        iii. The Placement Coordinator will direct the assigned support coordinator to immediately implement the choice process (with emergency temporary alternative placement, if necessary) to identify a new provider for the person. RCS staff must be present at the choice meeting.
        iv. The Behavioral and Psychological Evaluator will review any other special staffing restrictions managed by the same provider for compliance and for the potential need for choice.

5.7. Regional Provider Meetings

Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30-.02
Statement: Regional Provider Meetings are conducted at least quarterly in each fiscal region and are organized by the applicable Regional Community Services office.
Purpose/Intent: Regional Provider Meetings are conducted to ensure ongoing communication with certified service providers and support coordinators about Waiver services, standards and accountability, and to offer opportunities for feedback and guidance, as well as progressive training on applicable standards, policies and processes.
Scope: Director of Community Programs; Regional Community Services; Support Coordinators; Service Providers Definitions: N/A
Procedures:

1. Regional Provider Meetings are held at least quarterly in each of the five fiscal regions.
2. Prior to each meeting, an email is sent to all Providers and Support Coordination agencies requesting suggestions for topics, along with a save-the-date notification.
3. An email is sent to all Providers and Support Coordination agencies with the upcoming agenda, including any current mandatory topics, and final meeting arrangements.
4. The meeting is held on the identified date, with a sign-in sheet required or conducted virtually.
5. Handouts are available to all providers, as applicable.
6. Copies of sign-in sheets and handouts are sent via email to Central Office Certification and Quality Enhancement.
7. Original records of the meeting are maintained at the Regional Office.

5.8. Provider Name Change Process

Responsible Office: Office of Quality & Planning
Reference: ADMH Administrative Code 580-5-30
Statement: By following this process, providers will have all the necessary information required to when making a name change for their organization.
Purpose/Intent: To provide a process for agencies wanting to change their name.
Scope: Office of Quality and Planning, Office of Certification Administration, Fiscal Office, Office of Systems Management, Contracts Office.
Definitions: Division of Developmental Disabilities Information Management System (DDD IMS); Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DDD)
Procedures:

1. Provider contacts the Office of Quality and Planning in writing to discuss the appropriateness of the proposed name change prior to contacting IRS. This is to ensure the proposed name is in keeping DD Administrative Code regulations.
2. The Office of Quality and Planning contacts the Provider in writing of the preliminary approval of the name change.
3. Provider contacts and provides necessary information to the IRS requesting a name change.
4. Provider submits IRS paperwork and National Provider Identification (NPI) application to the Office of the Secretary of State.
5. Provider submits approved paperwork above to the Office of Certification Administration (OCA) with a one-page application to request a name change.
6. The OCA forwards application and supporting paperwork to DD Certification and cc's the Contracts Office, Fiscal Office, and the Office of Systems Management. From this point forward through the process, all correspondence should be copied to all persons/offices involved until completion.
7. DD Certification reviews and approves and forwards to OCA. 8.OCA forwards to the Fiscal Office and Contracts Office.
8. The Fiscal Office Completes C1 Contract form and forwards to the Contract Office.
9. The Contracts Office completes new contract and forwards to Finance Office.
10. The Finance Office reviews and approves and forwards back to Contracts Office.
11. The Contracts Office notifies the provider of the approved name change via new contract, provider completes the contract and returns to the contracts office which obtains the commissioner's signature to execute the contract.
12. The Contracts Office forwards the information to Office of Systems Management.
13. The Office of Systems Management advises provider to submit claims for the first checkwrite of the next month (the largest) and then hold all claims until notified. During this time the request to change the name is forwarded to Medicaid.
14. Medicaid updates new name in Payment System.
15. Medicaid notifies the Office of Systems Management of updated name change.
16. The Office of Systems Management updates name change in DDD IMS and notifies all ADMH-DDD staff.
17. The office Systems Management notifies provider of name change in DD IMS and advises provider to contact STAARS and resume claims submissions.

18. Provider contacts STAARS.

5.9. New Systems Software Releases

Responsible Office: System Management
Reference: DDD Information Management System Manual
Statement: All system users will be informed of updates to the system
Purpose/Intent: To ensure all users have the most updated information for consistency
Definitions: DDD IMS (Division of Developmental Disabilities Information Management System)
Procedures:

1. The functional analyst is notified and is provided the Release Notes by the vendor.
2. Once received, the functional analyst reviews each line item of new feature/software update provided in the Release Notes. According to specifications, each update is tested to assure changes were successful and did not affect other components of the system.
3. In the Release Notes, each line item's "Affected Area", "Topic", and "Summary" of events is reviewed and tested. End users are also asked to participate in the testing as it pertains to their duties.
4. Tests are conducted in the "Alabama Acceptance" site.

https://fwtest.harmonyis.net/AlabamaAcceptance/Pages/Login.aspx?ReturnUrl=%2fAlabamaAcceptance%2f

5. This test site should be updated by the vendor with the new release of the software version along with the current data
6. Once all testing is completed and approved by the functional analyst and management, the vendor is notified to push the updates from the test site, Alabama Acceptance Test Site, to the DDD IMS Live Site
7. **The DD Division Functional Analyst issue an e-mail for all system users as notification of the changes and/or updates in the system**

5.10 Direct Service Provider Operational Requirements

Responsible Office: Support Coordination (Case Management)
Reference: Alabama Administrative Code 580-5-30, 580-1-4, 580-3-2, 580-2-5, 580-3-22,580-3-23, 580-3-26, OG 4.7 Conflict Free Support Coordination/Case Management Services, OG 7.3 Comprehensive Support Systems CSS Teams.
Effective: May 1, 2021
Statement: Person-Centered Planning invites everyone to organize the person's supports and services, so they can live the kind of life they want for themselves.
Purpose/Intent: The purpose of this guideline is to provide direction and information on non-support coordination agency provider roles. Providers will conform to all applicable Federal and State Medicaid Waiver and Home and Community Based Services Setting rules.
Scope: DDD HCBS Waiver Service Providers, ADMH-DDD Central/Regional Offices
Definitions:
Procedures:

1. **Provider Agency Operational Requirements:** (See the Assessment Tools for the Certification Operational Guidelines) The following operational requirements are established for all Provider Agencies to support person-centered planning practices.
    a. Promotion and Protection of Individual Rights:
        i. The provider agency implements policies and procedures that clearly define its commitment to and addresses the promotion and protection of individual rights.
        ii. The provider agency participates in the discussion at the annual meeting to ensure people are informed of their rights. The Support Coordinator documents the conversation and provides a copy of the Rights & Responsibilities form to the provider agency.
        iii. The provider agency provides individualized supports/services that are free from discrimination (race, gender, age, language, ethnicity, disability, religion, sexual orientation, or financial circumstances).
        iv. The provider supports individuals to make their own decisions about their supports and services and ensure decision-making supports are provided to people as needed.
        v. The provide ensures all staff are trained to recognize and honor people's rights.
        vi. The provider agency upholds due process requirements and follows applicable procedures.
        vii. The provider agency implements a formal grievance policy and procedure and informs individuals of the policy annually.
        viii. The provider agency has access to a working and effective Human Rights Committee.
    b. Dignity and Respect:
        i. Provider agency policies and procedures ensure people are treated as people first.
        ii. Provider agency respect people's concerns and have a system in place to respond to any concerns accordingly.

iii. Provider agency ensure people have privacy
iv. Providers ensure all supports and services enhance dignity and respect
v. Providers work with Support Coordinators and communities to ensure people have meaningful work and activity choices

c. Protection from Abuse, Neglect, Mistreatment and Exploitation
   i. The Provider agency implements policies and procedures that define, prohibit and prevent abuse, neglect, mistreatment and exploitation and ensure support staff are properly trained.
   ii. The Provider agency follows reporting and investigation requirements, including notification to Support Coordination agencies, for allegations or suspected incidents of physical, verbal, sexual or psychological abuse, mistreatment, neglect or exploitation regardless of age.

d. Best Possible Health:
   i. Provider agency ensures people have support and access to manage their own health care.
   ii. Provide agency ensures health needs are addressed in a timely manner.
   iii. Provider agency staff immediately recognize and respond to medical emergencies and inform Support Coordinators about any changes in health status
   iv. Provider agency ensures people receive medications and treatments safely and effectively.
   v. Provider agency has policies and procedures that are in accordance with the Alabama Board of Nursing Regulations.

e. Safe Environments:
   i. The provider agency provides individualized safety supports as outlined within the PCP.
   ii. The provider agency protects people from abuse, neglect, mistreatment, and exploitation and follows all procedures within the Incident Prevention Management System (IPMS).
   iii. The provider agency ensures the physical environment promotes people's health, safety, and independence.
   iv. The provider agency has individualized emergency plans.
   v. The provider agency conducts routine inspections to ensure environments are sanitary and hazard free.
   vi. The provider agency ensures staff are qualified for their roles and implements an ongoing staff development program.

f. Staff Resources and Supports:
   i. The provider agency ensures staff are trained on Quality Improvement, PCP foundations, and PCP implementation strategies.
   ii. The provider agency implements a system for staff recruitment and retention that is in accordance with all applicable laws and agency requirements.
   iii. The provider agency implements policies and procedures that promote continuity and consistency of staff.

g. Positive Services and Supports:

i. The provider agency ensures people are informed about the services and supports they provide.
ii. The provider agency providers continuous and consistent services and supports for each person as outlined in the PCP.
iii. The provider agency monitors and reports the effectiveness of each support and service they provide as outlined within the PCP.
iv. The provider agency provides positive behavioral supports to people and ensures people are free to unnecessary, intrusive interventions.
v. The provider agency treats people with psychotropic medications for mental health needs consistent with standards of care.

h. Continuity and Personal Security:
i. The provider agency has a governing board and leadership team that provides transparent guidance and direction
ii. The provider agency has clear mission and value statements aligned with person-centered planning philosophy they are accountable to.
iii. The provider agency supports people to manage and access their personal money and reports details about how money was spent to the Support Coordination agency.
iv. The provider agency has business, administrative, and support functions that comply local, state, federal requirements.
v. The provider agency has a cumulative record of personal information that upholds confidentiality and promotes continuity of services.

i. Quality Improvement System:
i. The provider agency has a comprehensive plan and system outlined to measure the success of the organization in meeting its desired outcomes and the outcomes outlined within the Quality Improvement Tool.
ii. The provider agency has monitoring data that is accessible and used for continuous learning and improvement.

j. Conflict of interest:
i. Provider agencies have a conflict-of-interest policy and procedure.
ii. Provider agency staff will avoid conflicts of interest that interfere with the timely and effective assessment, planning, and support of individuals who receive services from their agency.

2. **Effective Person-Centered Planning Practices:** The following practices are established for all Provider Agencies in collaboration with the Support Coordinator:
a. Use of most integrated setting as documented in the Person-Centered Plan:
i. As part of identifying strategies to achieve the individual's desired life and defined outcomes during the individual's person-centered planning process, will focus on community-based service options prior to exploration of residential placement or facility-based services.
ii. Service delivery includes paid and unpaid services and supports by waiver and/or other service providers (e.g., Medicaid State Plan providers, ADRS providers, special/general education provider, and generic community service providers), friends, family, and other natural support networks.

b. Assessment resources and procedures:
    i. Provider agencies will utilize assessment and planning resources and procedures approved by ADMH-DDD. A list of the documents required to be completed is listed in Appendix 1 below. All forms listed are to be completed, as applicable, to each person/situation and will be provided to the Support Coordinator one week prior to the PCP meeting for discussion at the meeting.
        - Resources, procedures, and other information related to the Providers role and the Support Coordinator's role in person-centered planning are listed on the ADMH website: https://mh.alabama.gov/training/
    ii. Providers Agencies will provide information in a strength-based way to the Support Coordination agencies during the person-centered planning discussions.
    iii. Providers will be an active participant in person-centered planning conversations and attend the Team Meeting. They will provide information during the initial 30 days a waiver participant is enrolled, every time there is a change in condition, and minimally every 90 days after that.
        - If the plan is not available, the provider agency must show documented evidence of efforts to obtain the documentation.
    iv. Providers will provide information to support the person-centered planning process to the Support Coordination agency including:
        - Any information to identify a person's outcomes, hopes, or dreams
        - All possible strategies to achieve an individual's desired outcomes and how those strategies will be implemented by the individual, natural support network, community supports, and paid services and supports.
        - Information to support back-up or continency planning should any services or supports be unavailable for any reason.
        - All assessment forms as applicable to each person/situation one week prior to the PCP meeting for discussion at the meeting.
        - Any other information they have related to personal or health information from outside sources.
    v. Within 30 days after the Person-Centered Plan has been completed, a copy of the person-centered plan and assessment will be provided to the provider agency. The provider will sign the person-centered plan and return a copy to the Support Coordination agency. The provider will implement the agreed upon strategies, including but not limited to the person-centered plan. The provider will report progress towards goals at least every 90 days.
c. Natural Support Networks:
    i. Provider agencies ensure there are a variety of methods for helping people stay connected to their natural supports.
    ii. Provider agencies will work with the Support Coordinator to identify strategies to meet the desired level of contact with natural supports identified during the person-centered planning conversations.
    iii. Provider agencies ensure staff and volunteers are provided training to develop and/or improve skills to support people's communication with natural supports, especially families and friends.

d. Behavioral Support Plans:
    i. If appropriate, individuals have a Behavior Support Plan that reduces, replaces, or eliminates specific behaviors and are implemented according to ADMH-DDD's Behavioral Services Procedural Guidelines.
        - Behavior Support Plans are created by the provider agency in partnership with the Support Coordinator and documented within the Person-Centered Assessment and Plan.
    ii. Behavior Support Plans are approved by the individual's Support Team.
        - Behavior Support Plans with level 2 or 3 procedures are reviewed and approved by the Behavior Review Committee, the Human Rights Committee, and the individual or individual's legally authorized representative.
    iii. Behavior Support Plans are reviewed at least quarterly, or more frequently as required by the individual's needs, for effectiveness and appropriateness.
    iv. Highly intrusive behavior interventions or punishment for the convenience of staff or in lieu of a Behavior Support Plan are not permitted.
e. Crisis planning and intervention:
    i. Provider agencies will follow the CSS Team operation guideline found in OG 7.3.
f. Risk Management:
    i. Every person has the right to make informed decisions of their choosing necessary for individual growth and development. Provider agencies will support dignity of choice and risk, allowing for self-determination related to reasonable risks of personal choices.
    ii. Provider agencies are responsible for:
        - Identifying and evaluating potential positive and negative risks associated to choices made by the individual.
        - Identifying the person's tolerance for accepting and taking that associated risk related to the person's goals and preferences.
        - Development and communication of risk strategies for choices the person determines are worth accepting and taking.
        - Identifying methods and processes to monitor the effectiveness, updates, and continued use of risk mitigation strategies.
        - Communicating any risks identified and risk mitigation strategies for each individual to the Support Coordinator as part of the person-centered assessment and plan.

3. **Collaboration:** Provider agency staff will collaborate with Support Coordinators and other service providers to identify, assess, and implement person-centered plans and community resources to enhance service options.
    a. Provider agencies will partner with paid and unpaid service providers to identify opportunities for innovative practices to implement person-centered planning.
    b. Provider agencies will monitor the implementation of person-centered plan strategies and partner with Support Coordinators and other providers to improve effectiveness and address any training gaps.

Appendix 1:

Current Form/ Process	Provider Responsibility	SC Responsibility
* Functional Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings for assistance with ADLs and IADLs within the barriers (core issues) section of each domain as appropriate within the PCP
Nursing Assessment (include self-administration of medication)	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Overall Health subsection of the Healthy Living Domain
* Financial Assessment or Money Management Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Finances subsection of the Community Living Domain
Fall Risk Assessment (may be part of nursing assessment)	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Safety subsection of the Community Living domain
Behavior Support Plan	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the MH & AODA subsection of the Healthy Living Domain
Medication Reduction Plan or Psychotropic Medication Plan	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Medications subsection of the Healthy Living Domain
* Safety Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Safety subsection of the Community Living Domain
Key Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Access to Possessions subsection of the Community Living domain
Lease Contract	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Living Situation subsection of the Community Living domain

This list is not all-inclusive list, provider agencies should continue to follow current approved administrative standards. Providers will also provide a summary of the physical results, including Aims.

* These documents are always required regardless of services received. For Self- Directed Supports, the Support Coordinator is responsible for completing these forms.

CHAPTER 6
QUALITY MANAGEMENT

6.1. Certification Review Process

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30
Revised: May 6, 2021
Statement: This process is to guide certification staff in assessing community providers' success in providing quality services and supports.
Purpose/Intent: To provide the process for certification of community providers of services to people with developmental/intellectual disabilities.
Scope: DDD HCBS Waiver Service Providers/Support Coordinator Services/ADMH-DDD Central/Regional Offices
Definitions: Factor- The main topic in the administrative and support requirements for community providers of services. Indicator-Used to set expectations for each factor. Probe-Used to evaluate how well the organization meets each indicator.
Procedures:
It is strongly recommended providers complete a self-assessment using the "Assessment Tool for Certification," prior to the review. This will enable providers to evaluate their own positions in regard to the standards and provide an opportunity to gather materials pertinent to the review.

Important Notice: In an effort to provide due diligence in ensuring ADMH Division of Developmental Disabilities (DDD) is in full compliance of regulatory requirements related to the Home and Community-Based Services (HCBS) Settings Rule, as evidenced by its ongoing provider self-assessments, validation, and transition to compliance requirements process, DDD is suspending approval of any new requests for deemed status at this time. In consideration of the CMS requirement to continue to ensure HCBS Settings compliance, the Division will assess the merits of removing the suspension of deemed status at a later date, but not before March 2023, the date all states must be in full compliance with the HCBS Settings Rule.

1. One month prior to the review, the agency will be requested to submit a roster of all individuals receiving services through the organization, with demographic and other information pertinent to the review.
2. The Certification Staff will select a sample of people supported to use during the review.
    - If the population of the organization is 30 or less, the sample will be 2 people.
    - If the population of the organization is 31-60, the sample will be 3 people.
    - If the population is more than 60 people, the sample will be 5% up to a maximum of 15 people.
3. The Certification Staff reserves the right to increase the interview sample to better represent the population being supported by the organization.
4. Approximately one week prior to the review, the Certification Staff will notify the provider of people identified for the sample.

5. Provider staff will contact those individuals and arrange for interviews, reviews of records pertaining to those people, and follow-up conversations with staff who know them well.
6. The Certification/Quality Enhancement Staff will conduct a Personal Outcome Measures interview with each person in the sample.
7. The Certification Staff will conduct record reviews of each person in the sample. The staff will review assessments, medication administration records, person-centered planning documents, and other records to validate the organization's systems and practices.
8. Settings reviewed by Certification Staff will represent all types of settings in which services are provided by the organization and complement the persons to be interviewed. Certification Staff reserve the right to visit any setting in which services are provided receiving services.
9. Each organization will be assessed in the areas of:
10. Factor One: Rights Protection and Promotion
11. Factor Two: Dignity and Respect
12. Factor Three: Natural Support Networks
13. Factor Four: Protection from Abuse, Neglect, Mistreatment and Exploitation
14. Factor Five: Best Possible Health
15. Factor Six: Safe Environments
16. Factor Seven: Staff Resources and Supports
17. Factor Eight: Positive Services and Supports
18. Factor Nine: Continuity and Personal Security
19. Factor Ten: Quality Improvement System
20. Factor Eleven: Other Requirements Supporting Protection, Health and Safety
21. Factor Twelve: Personal Care, Companion, Respite and Crisis Intervention Services, and Supported Employment Services at an Integrated Worksite (non-congregate services)
22. Factor Thirteen: Support Coordination Standards
23. (Factors 12 and 13 only if those services are provided)
24. The criteria for Factors Four- Protection from Abuse, Neglect, Mistreatment and Exploitation, Five- Best Possible Health, and Six- Safe Environments is set at 100%. The system and practice for all Indicators in each Factor must be present to meet the 100% mark. Additional requirements in these areas are captured in Factor Eleven, which is scored differently.
25. For Factors One, Two, Three, Seven, Eight, Nine, Ten, Eleven, Twelve, and Thirteen, each Factor is composed of several Indicators. Each of the Indicators in Factors One through Three and Seven through
26. Thirteen are assessed and a rating made on one of the following criteria:
27. Action Required (AR)-Incomplete planning and action.
28. Progress Noted (PN)-Planning and action has occurred with evidence of partial results.
29. Effective Results (ER) -Actions are demonstrating the desired results.
30. Probes, correlating with the requirements in Chapter 580-5-30, Intellectual Disabilities Services, are included in this Assessment Tool as a means of discovering information about the Indicators and making rating decisions. They are not scored separately but are used to gather information to support the decision about whether the Indicator is being met satisfactorily.
31. The reviewer will decide about each indicator based on the information gathered through conversation, spending time with people, and review of documents. The reviewer will evaluate compliance with requirements within the indicator and then make a final determination about

the indicator based on a preponderance of the information gathered. The reviewer will note Supporting Information for all Indicators rated "Action Required" (AR) and for those individual standards within Indicators rated "Progress Noted" (PN).

32. Each organization will be subject to the requirements in Factors and Indicators (Exhibit 6.1) based on the types of services provided (see chart following this discussion). The total number of the Indicators applicable for that organization is multiplied by 80% to determine the required number of met Indicators for a One Year Certification and 90% for a Two-Year Certification. Rounding is applied to the nearest whole number, with .5 being rounded up. Individual Indicators determined by the reviewer to be not applicable will be deleted from the total Indicators required for that organization and this will be factored into the scoring.
33. The organization's indicator rankings are added together to obtain the total number of indicators meeting the "Progress Noted" (PN) and/or "Effective Results" (ER) status.
34. If the organization does not meet the 100% criteria for Factors Four, Five and Six, AND/OR does not meet the minimum of 80% on other applicable Indicators, the organization will be determined not in substantial compliance with standards and will not be certified. The organization may be placed on Provisional Certification Status for up to sixty (60) days, and a Plan of Action to address Indicators rated "Action Required" and "Progress Noted" must be submitted to the Office of Certification Administration within thirty (30) days from receipt of the letter from that Office. Timeframes to come into full compliance with the indicators must be included in the Plan of Action. Failure to submit the Plan of Action within the time period specified may result in the immediate decertification of the organization's programs. Prior to the expiration of Provisional Certification status, the programs will undergo a follow-up site certification review to determine future certification status. If the organization fails to come into full compliance during the follow-up site review, the Provisional Certification will be extended, and a new Plan of Action may be required. Continued failure to come into full compliance may result in a recommendation for Decertification to the Commissioner.
35. If the organization does not meet the 100% criteria for Factors Four, Five AND/OR Six, the organization will be required to participate in mandatory training from the Regional Community Services Office relating to the area(s) cited. Failure to participate may result in immediate decertification of the organization's programs.
36. If the organization meets the 100% criteria for Factors Four, Five and Six, AND receives either PN or ER on a minimum of 80% of the other applicable Indicators, the organization is certified for one year and a Plan of Action to address Indicators rated "Action Required" and "Progress Noted" must be submitted to the Office of Certification Administration within thirty (30) days from receipt of the letter from that office.
37. If the organization meets the 100% criteria for Factors Four, Five and Six, AND receives either PN or ER on a minimum of 90% of the other applicable Indicators, the organization is certified for two years.
38. Certification Staff will review policies and procedures of the organization that provides information about systems and practices. Targeted interviews will focus on the specific reason the person was selected.
    - Someone who has been involved in a recent allegation of mistreatment
    - Someone who has filed a grievance/complaint
    - Someone who has agreed to a restrictive intervention/rights limitation

- Someone who has had a reportable incident in the last three months
- Someone who has had an emergency room trip or hospitalization
- Someone who has significant health care supports
- Someone who has a modified diet (preferably texture)
- Someone who is new to service
- Someone who has consented to research

Others will be reviewed to gain information about specific organizational practices. The Certification Staff may select people from this list as part of the representative sample or as additional people to have conversations about specific issues. However, this list is not exhaustive and/or mandatory. The selection of people for targeted interviews is tailored to meet the characteristics and needs of each organization.

39. The Certification Staff will have additional conversations with direct support staff, professional staff and others to gather information about the organization's systems and practice and may also review additional documentation about the topic of interest.
40. In the course of spending time with people, targeted interviews or review with people selected to be in the sample, the Certification Staff may ask questions of other people supported.
41. The Certification Staff may have a conversation with at least one family member/advocate/ legally authorized representative. The selected person may be someone who is present during the review, related to someone in the sample, or someone who the Certification Staff has identified as someone who will be able to provide information helpful in reviewing the organization's systems and practices or it might be someone recommended by the organization.
42. The Certification Staff will review records for a sample of personnel, which will include staff providing services to people in the sample. The number varies depending on the amount of information needed to validate the organization's practices. Generally, the sample size will be 10% but no less than 6 people and no more than 30 people.
    - Direct Support Staff
    - One person who has been employed 3 to 6 months.
    - One person who has been employed more than one year.
    - Professional Staff Examples (as applicable)
        - Nurse
        - QDDP
        - Support Coordinator
43. The Certification Staff will have conversations with organization leaders about the systems and practices. Some questions will be focused on specific systems like the Human Rights Committee, Safety or Quality Assurances/Quality Improvement System monitoring, or facilitation of individualized goals and objectives identified in the Person-Centered Plan. Other conversations will be more general about policies or practices of the organization.
44. At the closing meeting, the Certification Staff will provide general feedback about their findings. In addition to members of the organization undergoing the certification review attending the closing meeting, findings relating to Person Centered Plans may require attendance by the leadership of the Support Coordination Agency and the ADMH Support Coordination Liaison. Person-Centered Planning should be a collaborative effort that ensures a comprehensive plan, unique to the individual served, is developed. Opportunities ensuring Direct Support providers and Support Coordination Agencies work collaboratively to identify individualized support

needs, must be evident during the certification review. The ADMH Support Coordination Liaison should be available to develop a Technical Assistance Plan for the Support Coordination Agency that ensures a comprehensive Person-Centered Assessment is available for provider implementation.

6.2. Provider Training and Technical Assistance

Responsible Office: Quality and Planning
Reference: ADMH Administrative Code 580-5-30-.11; Assessment Tool for Certifications Reviews
Revised: April 23, 2021
Statement: Quality Enhancement specialists provide training and technical assistance to community provider organizations in various system areas as required by the Division of Developmental Disabilities.
Purpose/Intent: This procedure sets out to identify areas in which service providers may need assistance with agency-specific processes, training and the development of policies and procedures to improve the quality of individual and organizational supports.
Scope: These procedures apply to all DDD employees, subcontractors, providers, vendors, consultants, volunteers, and governmental agencies that provide services and supports to people with intellectual and developmental disabilities.
Definitions: Quality Improvement System: The internal monitoring system measures the most important elements and key functions of the organization. Data sources, methods for data collection and the type of data analysis to be performed are clearly identified for each function measured. Qualified Developmental Disabilities Professionals (QDDP) is a DD professional with at least one year of experience working directly with persons with ID, holds a bachelor's degree in a human service field, and has completed a series of required training as referenced in the ADMH Administrative Code.
Procedures: Regional QE staff provide training and technical assistance in the following areas:

1. Quality Improvement System
    a. Alabama, in partnership with CQL, re-designed and implemented new Administrative and Support Requirements for Community Providers of Services for People with Developmental Disabilities, effective January 14, 2021.
    b. 580-5-30 requires that the organization has a system of internal monitoring that measures compliance with basic assurances and is designed to enhance quality.
        i. The organization monitors Quality Improvement.
        ii. A comprehensive plan describes the methods and procedures for monitoring Quality Improvement.
        iii. Quality Improvement monitoring data is used for continuous learning and improvement.
2. QDDP Training
    a. The Council on Quality and Leadership has developed these 9 training modules for human service providers in Alabama, in partnership with the Alabama Department of Mental Health/Division Developmental Disabilities. The password can be obtained from the Office of Quality and Planning and the curriculum can be accessed at https://c-q-l.org/ALtraining
        - QDDP Overview
        - Health, Safety, and Medical
        - Overview of Assessments
        - Know Your Rights
        - Nurse Delegation
        - Person-Centered Planning
        - Administrative Code

- Incident Prevention and Management System
- Behavioral Support Planning

3. Incident Prevention and Management System
    a. Falls
    b. Medication Errors
    c. Abuse
    d. Neglect
    e. Exploitation
    f. Intimacy and Personal Relationships
4. Fatal Five
    a. Aspiration
    b. Bowel Obstruction
    c. GERD
    d. Seizures
    e. Infection/Sepsis

For additional training offerings, please see the Procedural Guidelines for Personal Outcome Measures and Person- Centered Thinking.

As an ongoing quality improvement initiative, the regional QE staff will identify trends through the review of quarterly incident reports that are submitted in Therap. Additional trends will be noted through routine monitoring conducted by regional community services staff. Finally, QE staff will have an opportunity to identify trends by conducting in-person Personal Outcome Measure (POM) interviews with people receiving services and the organizations that support those people and by attending certification exit meetings.

Based on training and TA needs, QE staff may announce services to community providers individually or collectively. Provider may also contact QE staff upon request to receive training and technical assistance. To request technical assistance or training, please contact the Quality Enhancement Specialist in your region:

Region I Quality Enhancement Region I Community Services
Phone: (256) 552-3712
Fax: (256) 355-0551
Cell: (256) 566-5729
Region II Quality Enhancement Region II Community Services
Phone: (205) 554-4309
Fax: (205) 554-4340
Cell: (205) 792-9427
Region III Quality Enhancement Region III Community Services
Phone: (251) 478-2770
Fax: (251) 450-3798
Cell: (251) 751-0139
Region IV Quality Enhancement Region IV Community Services

Phone: (334) 676-5584
Fax: (334) 676-5591
Cell: (334) 312-5637

Region V Quality Enhancement Region V Community Services

Phone: (205) 916-7764
Fax: (205) 916-7810
Cell: (205) 215-1384

6.3. Developmental Disabilities Certification Policy and Procedure Requirements

6.3.a. Non-Waiver Home and Community Based Services (HCBS)

Responsible Office: Quality Management
Reference: Alabama Administrative Code 580-1-4, 580-2-9,580-2-20, 580-3-25, 580-3-26, 580-5-30
Effective: October 1, 2020
Statement: The organization will comply with requirements of DMH Standards and Community Standards for Services for Persons with Intellectual Disabilities except for state and federal guidelines relating to Home and Community Bases Waiver Services.
Purpose/Intent: The purpose of this Operational Policy is to provide certification policy and procedure requirements for agencies delivering services and supports to individuals that do not meet HCBS requirements.
Scope: DDD Non-Waiver HCBS Providers
Definitions: • Non-Waiver HCBS Provider- A provider that does not provide HCBS Medicaid Waiver Services. • Non-Waiver HCBS Setting- A setting that does not provide HCBS Waiver Services and does not receive HCBS Waiver funding. • 2014 HCBS Settings Rule – Federal Regulations set forth for HCBS Waiver Services/Settings.
Procedures: All Intellectual Disabilities services that are not required by the HCBS Waiver will be provided in accordance with the DMH Standards and Community Standards for Services for Persons with Intellectual Disabilities. The certification review process will be conducted in accordance with Operational Policy 6.1. Appropriate certifications will be maintained in accordance with applicable standards.
Community service providers will maintain records on all individuals receiving services and/or supports in accordance with DMH Standards, applicable state and federal programs and laws such as Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.
Contracted non-waiver HCBS providers must have written policies and procedures that are effectively implemented in such a way as to assure the health, safety, and individual security of individuals receiving services and supports.
The organization's written policies and procedures will be approved, reviewed, and updated by the governing board, as appropriate but at least annually and available to all employees and individuals receiving services and supports. All employees will be trained on the policies and procedures including what constitutes effective and appropriate implementation of each policy and procedure.
Policies and procedures, as well as evidence of implementation, will address, at a minimum, the following areas:

1. Protection from abuse, neglect, mistreatment and exploitation.
2. Best possible health.
3. Safe environments.
4. Staff resources and supports
5. Positive services and supports.
6. Continuity and personal security.
    a. Policies and procedures to address the overall requirements of the governing body, business, and administrative supports of the individuals served.

b. Policies and procedures to address fiscal practices in managing individuals' funds and other personal resources.
c. Policies and procedures to address business practices, which includes maintaining a record of information promoting continuity of services and security of individual information, in support of individuals served.

7. Quality improvement system.

All policies and procedures will meet the requirements as outlined in the Department of Developmental Disabilities' Operational Policy.

6.3.b. Promotion and Protection of Individual Rights

Responsible Office: Quality Management
Reference: Administrative Code 580-5-30, 580-3-26, Home and Community Based Services Settings (HCBS) Rule
Effective: October 1, 2020
Revised: March 26, 2021
Statement: This process is to guide certification staff in assessing community provider compliance with providing quality supports in the area of individual rights.
Purpose/Intent: To provide a process that ensures the provider practices sound management providing quality services to individuals.
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services
Definitions: Home and Community Based Services (HCBS) Settings Rule - The Centers for Medicare and Medicaid Services (CMS) issued the HCBS Settings Rule to require that every state ensure services delivered to people with disabilities living in the community meet minimum standards for integration, access, to community life, choice, autonomy, and other important protections.
Procedures

A. The Organization Implements Policies and Procedures That Clearly Define Its Commitment to and Addresses the Promotion and Protection of Individual Rights of Individuals.

1. The policy lists rights afforded all citizens as indicated by the (US) Constitution, laws of the country, and the State of Alabama.
2. The policies and procedures describe the organization's due process.
3. The policies and procedures for due process include individual rights review and documentation in the event of a proposed restriction of an individual's rights.
4. The organization refrains from having standing policies and procedures that restrict an individual's rights without due process.

B. The Organization Informs People of Their Rights.

1. The organization documents verification that it provides to individuals and their legally authorized representatives an oral and written summary of their rights/responsibilities and how to exercise them upon admission and annually thereafter.
2. The information (in line 1 above) is provided in a format that is in language and style that is easily understood by the individual.

C. The Organization Supports People to Exercise Their Rights and Responsibilities.

1. The organization assesses each individual's ability to understand and exercise his or her rights on an ongoing basis but at least annually

2. The rights assessment addresses individual's civil and legal rights and individual freedoms. The assessment includes but is not limited to the ability to do the following-
    a. Exercise freedom of movement with physical environments, including units with lockable entrance doors, with individuals served and only appropriate staff having keys and will be documented in the person-centered plan, If more than one bedroom, each bedroom should be considered a unit and the "tenant"' should have a key to their lockable door. This rule applies to Home and Community-Based Services (HCBS) and settings
    b. Have a lease, residency agreement or other form of written agreement in place that provides protections, and addresses eviction processes and appeals comparable to those provided under the state's landlord tenant law.
    c. Manage money
    d. Send and receive mail including a private place to read and open mail.
    e. Privacy to make and receive phone calls and use other means of communication.
    f. Have visitors of their choosing at any time. Any restriction of visitors or visitations of the individual's choice must be based on individualized, assessed that is documented in the person-centered plan along with what efforts that will be taken to try to reduce or move the restricted access as soon as may be feasible. This rule applies to Home and Community-Based Services (HCBS) and settings.
    g. Access individual possessions.
    h. Vote and otherwise participate in the political process.
    i. Make choices about religious affiliation and participation.
    j. Interact socially with members of either gender.
    k. Privacy including a choice of private bedroom or choice of a roommate with furnishings positioned to maximize privacy.
    l. Freedom and support to control schedules and activities. This rule applies to Home and Community-Based Services (HCBS) and settings.
3. The rights assessment addresses the need for and scope of advocacy, guardianship and alternatives for each person.
4. Rights assessment results, including supports needed to protect and promote the individual's rights, are documented in the individual's record.
5. The organization provides assistance to the person in areas identified as important by the individual and that individual's support team.
6. The organization provides education regarding voter registration and the voting process to anyone age 18 or over that expresses an interest.
7. The organization assists individuals with voting as needed. (Note: this is not applicable for individuals deemed incompetent due to Alabama voting laws.)
8. The organization provides individualized supports/services that are free from discrimination (race, gender, age, language, ethnicity, disability, religion, sexual orientation, or financial circumstances.)
9. The organization obtains written, informed consent (from the individual) prior to any intrusive medical or behavioral intervention, and prior to participation in research.
10. The consent contains information regarding procedures to be followed, expected benefits of participation, and the potential discomforts and/or risks.

11. The consent information is presented in a non-threatening environment and explained in a language that the individual can understand, and the individual is also informed that they may withhold or withdraw consent at any time.
12. The organization shares information about individuals only with their written, informed consent or that of their legally authorized representative.

D. Decision-Making Supports are Provided to People as Needed.

1. The organization refrains from presuming incompetence or denying individuals' rights to manage financial or personal affairs or exercise other rights solely by reason of his/her having received support services, unless legally determined otherwise.
2. Unless a legal determination of incompetence to participate in one or all of the following activities has been made, every individual is free to access courts, attorneys and administrative procedures, execute instruments, dispose of property, marry and divorce or participate in activities requiring legal representation, make choices regarding services and supports and who provides then without fear of reprisal, interference, or coercion. The individual is informed of all setting options including non-disability specific settings and an option for a private room in their setting. This information is documented in the person-centered plan.
3. Individuals receive only the level of support needed to make their own decisions. Supports include assisting individuals to advocate for themselves.
4. Each individual has a written plan to obtain advocacy, guardianship and alternatives to guardianship if those supports are needed. Support Coordination and Provider Organizations shall not serve in a guardianship capacity to those individuals that they directly or indirectly support.

E. Staff are Trained to Recognize and Honor People's Rights.

1. Staff are trained to recognize and demonstrate respect for individuals' rights including how individuals choose to exercise their rights.
2. Staff that complete rights assessments are trained to:
    a. Understand and support individuals' preferences in regards to rights,
    b. To identify goals related to exercising their rights and to support attainment of those goals
3. Staff are trained in due process procedures.
4. Staff are trained in any procedures for placing a limitation or restriction on an individual's rights.

F. The Organization Upholds Due Process Requirements.

1. The organization's due process is defined as providing individuals supported, and their legally authorized representatives, with a fair process requiring at least an opportunity to present objections to the proposed action being contemplated.
2. Due process, including review by a Human Rights Committee, is implemented when it is proposed that a individual's rights be restricted for any reason.
3. A Human Rights Committee (HRC) reviews any restriction of an individual's rights including an assessment indicating the need for the restriction periodically, but at least annually, during the period in which the restriction is imposed, and documents such.
4. All restrictions are included in the individual's person-centered plan. When any restrictions are being proposed for an individual, the individual is supported to attend and provide input at the HRC meeting in which the proposed restriction is being reviewed.
5. Individuals are provided adequate training in due process procedures including:

a. Any procedures for placing a limitation or restriction on an individual's rights'
b. Training that supports the removal of a rights restriction.

6. The continued need for the restriction is reviewed at least quarterly by the QDDP or more often at the request of the individual. All restrictions are included in the person-centered plan.

G. The Organization Has Access to a Working and Effective Human Rights Committee.

1. The organization utilizes a working and effective HRC that complies with the provisions of 580-3-26.
2. The HRC reviews policies, procedures and practices that have the potential for rights restrictions without individualized assessment.
3. The HRC reviews the frequencies and reasons surrounding the use of restraint for medical and/or behavior purposes.
4. The HRC meets at least quarterly.
5. The HRC is composed of a majority of individuals that are not employed by the program, and consisting of representatives from each of the following groups:
    a. Current and/or former service users,
    b. Family members of service users,
    c. Representatives of community support and advocacy organizations,
    d. Local official,
    e. Citizens at large,
    f. Performance Improvement/Quality Enhancement staff (ex-officio)
6. The HRC does the following:
    a. Makes recommendations to promote individuals' rights,
    b. Proactively promotes and protects individuals' rights,
    c. Reviews reports of substantiated allegations of abuse, neglect, mistreatment and exploitation,
    d. Reviews other data that reveals practices with respect to human, civil and legal rights,
    e. Reviews research projects involving human participation to ensure the protection of the individuals who are involved,
    f. Assists on the review of rights related policies and procedures,
    g. Promotes rights related education and training programs,
    h. Reviews rights restrictions,
    i. Assists in monitoring activities; advise the program administrator on consumer rights-related grievances, Reviews rights related issues in behavioral plans.

H. Services are Provided In a Safe and Humane Environment.

1. Adequate furniture, supplies and equipment are available as needed to support needs and outcomes of individuals served.
2. Furniture, supplies and equipment are in good repair and operating effectively.
3. Supplies, equipment or devices (such as adaptive, therapeutic, corrective, prosthetic, orthotic and mobility devices) that are for individual use are in good repair for the person who requires their use.
4. Food is available that is nutritious and is available in quantity and variety to meet individual's dietary needs and preferences and will be available at any time without restriction. Any restrictions to access to food must be based on individualized assessed need that is documented in the person-centered plan along with what efforts will be taken to try to reduce or remove the

restricted access as soon as may be feasible. This rule applies to Home and Community-Based Services (HCBS) and settings.

5. The organization maintains current certification and licenses for operations and complies with all posting and notification requirements of the local, state and federal offices.

6.3.c. Dignity and Respect

Responsible Office: Quality Management
Reference: Administrative Code 580-5-30
Effective: October 1, 2020
Revised: March 26, 2021
Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of dignity and respect.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Procedures:

A. Individuals Are Treated as Individuals First

1. The organization's policies and procedures reflect and reinforce.
    a. Courteous practices towards individuals,
    b. The avoidance of labels to describe individuals based on physical characteristics or disabilities,
    c. The practice of addressing individuals by their preferred names,
    d. Privacy in an individual's bedroom with furnishings selected and arranged by the individual, and
    e. Ensuring the setting is physically accessible to the individual.
2. The organization provides training to staff and volunteers on policies regarding dignity and respect
3. The organization's identifying information (name, letterhead, etc.) promotes a positive image of individuals, services, and supports.

B. The Organization Respects Individuals' Concerns and Responds Accordingly

1. The organization provides individuals supported and their legally authorized representatives with the information regarding filing complaints and grievances.
2. The complaint/grievance procedures include the name and telephone numbers of the local contact.
3. The designated local contact has the knowledge to inform individuals, families, and legally authorized representatives of the means of filing complaints and grievances and of accessing advocates, ombudsmen or rights protection within or outside the organization.
4. The grievance procedure information is available in frequently used areas, particularly where individuals receive services.
5. Notices include the toll-free numbers for the DMH Advocacy Office, the Alabama Disabilities Advocacy Program (ADAP), a federal protection and advocacy system, and the local Department of Human Resources office.

6. The organization provides access to individuals and advocates, including a DMH internal advocate and the grievance process, without reprisal.
7. Responses to grievances and complaints are provided in a timely manner per the agency's procedures.
8. Responses are made in a manner and format that is relevant and understandable.
9. The organization implements a system to periodically, but at least annually, review all grievances and complaints.

C. Individuals Have Privacy

1. The organization provides space for individuals to:
    a. speak or interact with others in private
    b. to open and read mail or other materials
2. The organization affords every individual the right to privacy.
3. Support staff demonstrate respect for individuals' privacy when:
    a. providing supports for bathing, dressing and personal hygiene in a private manner, and
    b. when entering personal spaces.

D. Supports and Services Enhance Dignity and Respect.

1. Practices enhance dignity and respect while recognizing individual choices and preferences.
2. Individuals receive needed supports to:
    a. ensure healthy hygiene and personal cleanliness
    b. choose clothing that is clean, fashionable, and fits
    c. decorate their personal spaces based on choice while maintaining environments that are safe and sanitary.
3. Transportation and other supports are provided so individuals can access community services in a manner similar to others.
4. The organization has policies related to privacy that address consent and the use of video surveillance and other electronic recording devices such as cell phones, cameras, video recorders, etc.

E. Individuals Have Meaningful Work and Activity Choices.

1. Personal assessments:
    a. identify preferred work and activities,
    b. identify practices to help individuals to make choices based on preferences and assist individuals to achieve goals.
2. Choices of activities and work encourage and promote age-appropriateness and a positive self-image. Options consider the individual's cultural background and preferences.
3. The organization provides individual assessments that identify preferred work activities, including assessing interest in competitive integrated employment, identifying practices to help individuals make choices based on preferences, and assisting individuals to achieve goals.
4. There are options for individuals that are age and culturally appropriate, normative, and promote a positive self-image and are identified preferences documented in the Person-Centered Plan (PCP) with appropriate goals and objectives.
5. The organization facilitates opportunities for competitive integrated employment and supports when employment is the choice of the individual and prescribed in the individual's PCP.

6.3.d. Natural Support Networks

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30
Effective: October 1, 2020
Revised: March 26, 2021
Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of natural support networks.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions: Natural Supports- Family, friends, and or community resources such as local organizations, clubs, places of worship, schools or other places where new and existing relationships can be built and facilitated outside of the organization that is important to the individual.
Procedures:

A. Policies and Procedures Facilitate Continuity of Natural Support Systems

1. The organization will have policies and procedures that define natural supports and acknowledge the
   importance of natural supports in promoting identity, personal security, and continuity for individuals served by the organization.
2. Natural Supports will be defined as family, friends, and community resources such as local organizations,
   clubs, places of worship, schools or other places where new and existing relationships can be built and facilitated outside of the organization.
3. Organizational policies and practices will reflect how to facilitate continuity in existing relationships and supports and or building new relationships using community resources.
4. Organizational policies and practices will reflect how organization will assist individuals in making and maintaining their natural supports.
5. Organizational policies and practices will reflect how organizations will assist individuals to contact their natural supports.
6. Organization's facilitation of natural supports will include promoting visits to the homes of families and friends to individual's setting. (NA for Day and Non-Congregate Services)
7. Organization's facilitation of natural supports will include promoting visits of families and friends to individual's setting. (NA for Day and Non- Congregate Services)
8. Organization's staff will consider individual's health, safety, and well-being while planning visits with family and friends. (NA for Day and Non-Congregate Services)
9. Training will be provided to staff and volunteers to develop and/or improve skills to support the individual's communication and contact with natural supports, especially families and friends.

B. The Organization Recognizes Emerging Support Networks

1. The organization will have a mechanism to identify and support existing and potential or emerging natural supports for each individual.
2. The organization will address ways to connect individuals to natural supports including addressing and overcoming barriers.

3. The organization will have strategies to build the capacity for natural supports based on individual's choices and preferences.
4. The organization will pursue the use of family members or close personal friends to assist individuals with decision-making.

C. Communication Occurs Among Individuals, Their Support Staff and Their Families

1. The organization will have internal communication systems for individuals, their support staff and families that:
    a. provides choices about extent and frequency of contact with their natural support networks.
    b. ensures inquiries from those in individuals' natural support systems are responded to in a natural and timely manner.
    c. has a mechanism for legally authorized representatives, and others identified by individuals to receive information and be notified promptly and compassionately of incidents involving the individual.
2. The organization will maintain written contact information including records of names, addresses, and phone numbers of family and friends who are important to individuals.
3. The organization will include a variety of methods for helping individuals stay connected to natural supports.

D. The Organization Facilitates Each Individual's Desire for Natural Supports

1. The organization will document individuals' satisfaction with the amount of contact with their natural support system.
2. The organization will document individuals' involvement with their natural support systems.
3. The organization will clearly identify expectations related to visits or other interactions with natural supports based on the desires of the individual being supported.
4. The organization will provide private space for visits and interactions with members of the individual's natural support network.

6.3.e. Protection from Abuse, Neglect, Mistreatment, and Exploitation

Responsible Office: Quality and Planning/Certification

Reference: Administrative Code 580-5-30, Community Incident Prevention and Management System (IPMS)

Effective: October 1, 2020

Revised: March 26, 2021

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of protection from abuse, neglect, mistreatment, and exploitation.

Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.

Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices

Procedures:

A. The Organization Implements Policies and Procedures That Define, Prohibit, and Prevent Abuse, Neglect, Mistreatment, and Exploitation.

1. The organization will implement a Community Incident Prevention and Management System (IPMS) as required by the Department of Mental Health (DMH), Division of Developmental Disabilities (DDD) to protect individuals served from harm and improve the organization's responsiveness to incidents for purposes of prevention of harm and risk management.
2. The organization will notify the DDD of all reportable incidents and take action in accordance with the Community IPMS.
3. The organization will develop policies and procedures that are consistent and comply with requirements of the Community IPMS. The policies and procedures will identify, define, prohibit, and prevent abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation.
4. Definitions of abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation will be comprehensive, specific, and consistent with Community IPMS definitions.

B. The Organization Promotes Freedom from Abuse, Neglect, Mistreatment, and Exploitation.

1. The organization will provide individuals with understandable information about their right to be free from abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation.
2. The organization will have a complaint process that is understandable and easy to use.
3. Individuals will be supported to report allegations of abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation.
4. Allegations reported by employees or others, including individuals supported by the organization, are managed consistently and in the same manner.
5. The organization will ensure individuals who cause injury or harm to themselves or others receive supports to replace those behaviors consistent with the Alabama Department of Mental Health, Division of Developmental Disabilities Behavioral Services Procedural Guidelines (DDD-PBS-01-05).
6. When there are allegations of abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation or other reportable incidents, the organization will take immediate action and ensure individuals are protected.
7. The organization will assist individuals who have been subjected to abuse, neglect, mistreatment, including the unauthorized use of restraints, or exploitation to access supports to address the effects of the abuse even if:
    a. The abuse occurred before they entered into the organization's system of services or
    b. The perpetrator is another individual who receives supports.
8. Incidents resulting in injury where both the perpetrator and the victim receive services will be investigated or clinically reviewed to determine:
    a. if the occurrence of such an incident may have been the result of neglect and/or
    b. if additional supports are needed for the individuals involved.

C. The Organization Follows Reporting Requirements for Allegations or Suspected Incidents of Physical, Verbal, Sexual or Psychological Abuse, Mistreatment, Neglect, or Exploitation Regardless of Age.

1. The organization will follow minimum protocols as specified in DMH/DD Community IPMS guidelines for reporting, investigation, and follow-up processes.
2. The organization will have procedures for reporting incidents and injuries in accordance with all applicable laws and DMH/DD requirements, including the Community IPMS.

3. The organization will notify an individual's responsible relative/guardian immediately in the event of a medical emergency or death.

D. The Organization Ensures Objective, Prompt and Thorough Investigations of Each Allegation of Abuse, Neglect, Mistreatment, and Exploitation, and of Each Injury, Particularly Injuries of Unknown Origin.

1. The organization will provide documentation that it conducts investigations in accordance with timelines established by the Community IPMS guidelines.
2. The organization will follow the recommendations for incident and investigation reports in the Community IPMS.

E. The Organization Ensures Thorough, Appropriate and Prompt Responses to Substantiated Cases of Abuse, Neglect, Mistreatment, and Exploitation and Associated Issues Identified in the Investigation.

1. The organization will document the internal investigation/review and follow up action of all allegations of abuse, neglect, mistreatment, including the unauthorized use of restraints, or exploitation.
2. The organization will ensure investigation outcomes and recommended actions are implemented in accordance with the Community IPMS Guidelines.
3. The organization will ensure an initial and comprehensive mortality review is completed and available.

F. Support Staff Knows How to Prevent, Detect, and Report Allegations of Abuse, Neglect, Mistreatment, and Exploitation.

1. The organization will ensure all staff receive orientation on what constitutes abuse, neglect, mistreatment, and exploitation. This includes prevention, detection and reporting requirements as specified in internal agency procedures, Community IPMS Guidelines, and any other applicable federal or state requirements.
2. The organization will ensure staff with specific responsibilities related to reporting, investigating, or documenting requirements contained in the Community IPMS receive appropriate training in their areas of responsibility and in specific procedures as well.
3. The organization's policy and practice will demonstrate continuous efforts to ensure freedom from abuse, exploitation, neglect or mistreatment are demonstrated. Efforts will include ongoing training in prevention, detection, and reporting and occur frequently enough, but at least annually, to support both individual and organizational outcomes.
4. The organization will provide training on specific supports, services, policies and procedures, or other corrective action deemed appropriate, immediately when support staff competency is identified as a (potential) causal factor for substantiated incidents of abuse, exploitation, neglect or mistreatment, including the unauthorized use of restraints, and exploitation.
5. The organization will evaluate potential underreporting and screening of allegations of abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation and provides additional training as needed.
6. The organization will develop and implement policies and procedures consistent with Section VIII of the Community IPMS and their internal quality improvement system process that reports incident data and identifies trends, patterns or isolated incidents that may be indicative of abuse, neglect, mistreatment or exploitation

6.3.f. Best Possible Health

Responsible Office: Quality and Planning/Certification

Reference: Administrative Code 580-5-30, Alabama Board of Nursing Administrative Code 610-X-7, MAS Nurse Manual

Effective: October 1, 2020

Revised: March 26, 2021

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of Best Possible Health.

Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.

Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices

Procedures:

A. Individuals Have Supports to Manage Their Own Healthcare

The organization's policies and procedures must ensure:

1. Individuals are given the opportunity to choose health care providers as desired.
2. Individuals are supported to make their own health care appointments and choices regarding their medical care as needed.
3. Individuals are provided understandable information about their current and past health conditions, their medications and their treatments, including the purpose, intended outcomes, side effects or other risks and alternatives.
4. Individuals have access to all their health care records.
5. An Individual's preferences and ability to self-administer medications and treatments are assessed at least annually in compliance with the Nurse Delegation Program.
6. Supports are available to assist individuals with medications and treatments if necessary.
7. Individuals are supported to become knowledgeable about how to access emergency medical care and to access it as needed.

B. Individuals Access Quality Healthcare

1. Within three hundred sixty-five (365) days prior to initial admission to a community-based program or service, each individual has a physical examination conducted by a licensed physician or certified nurse practitioner.
2. Individual's medical status and needs are reviewed annually within ninety (90) days prior to or at the same time as the annual Person-Centered Plan meeting. This is evidenced by a report from a physical examination by a licensed physician or certified registered nurse practitioner conducted within the last year.
3. Individuals are assisted in obtaining preventive and routine health services including physical examinations, immunizations, and screenings consistent with their age and risk factors as recommended by their personal physician. Preventive health care strategies/interventions contained in the Person-Centered Plan, based on the individual's current health status and age, are implemented and will be carried out according to the Centers for Disease Control recommendations regarding preventive/screening practices. Emphasis will be placed on age-specific screening tests.
4. Each individual newly admitted to a program has a TB skin test with documented results, unless there is written evidence that such testing was previously done or there is a medical

contraindication for the procedure. An annual TB skin test is conducted as medically indicated. If the skin test yields a questionable result, the organization follows up with a physician for necessary screenings and/or treatments.

5. Individuals who require supports for mobility are provided with assistance and supports to prevent skin breakdown. Individuals have therapeutic and adaptive equipment that fits them and is in good repair.

C. Health Needs Are Addressed in A Timely Manner

1. An individual who develops a medical problem, either an emergency or acute health care change, is assessed in a timely manner. Treatment/care and monitoring of the individual's condition is provided in accordance with good standards of nursing or medical care to resolve the problem effectively.
2. The organization has systems in place that ensure ongoing communication between individual's health care support staff and outside health care staff promotes continuity of care.
3. Each individual's Person-Centered Plan indicates his/her health needs and outlines specific actions and time frames to address these needs. Actions taken are documented. Health needs include, but are not limited to, physical, neurological, dental, nutrition, vision, hearing, speech/language, PT/OT,0 and psychiatric services.
4. When available, individual's records document hospital summaries that include the discharge diagnosis, current health status, necessary follow-up instructions and any restrictions or limitations of recent hospitalizations. Organizations shall document efforts to obtain hospital summaries.
5. Individual's records document acute health changes to provide a clear picture of the course of the illness or injury, the treatment provided, and the individual's current status from the time of identification through resolution.
6. As part of the Person-Centered Plan, health care plans and supports are modified in a timely manner based upon acute health care changes.

D. Staff Immediately Recognize and Respond to Medical Emergencies

1. Direct support staff (non-licensed medical personnel) receives training to recognize and respond to individuals experiencing medical emergencies.
2. Provide medical equipment ordered by a physician to respond in a potential emergency for pre-existing (known) conditions, ensuring it is well maintained, clean and functional.
3. Provide medication ordered by a physician to respond in a potential emergency in the appropriate dose, quantity, and form.
4. Ensure first aid kits are available and appropriately stocked for the provision of initial care for an illness or injury.

E. People Receive Medications and Treatments Safely and Effectively

1. Organizations implement policies and procedures approved by their Boards of Directors requiring full compliance with the Alabama Board of Nursing's Regulation 610-X-7-.06, Alabama Department of Mental Health Residential Community Programs.
2. The unit dose or individual prescription system is used for all prescription drugs.
3. All medications are labeled and stored in accordance with criteria herein.
    a. Medications are stored under lock and key.
    b. All narcotic medications, Schedule 2, 3, 4, and 5 are stored under double lock and key.
    c. Medications are stored separately from non-medical items.

d. Medications are stored under proper conditions of temperature, light, humidity, sanitation, and ventilation.
e. Internal and external medications are clearly labeled as such and stored separately from each other.
f. The organization is able to document ongoing accountability for all prescription medication through an inventory process.

4. Medications, both prescription and non-prescription, are administered and recorded according to valid orders and in compliance with the Alabama Board of Nursing's Regulation 610-X-7-.06, Alabama Department of Mental Health Residential Community Programs, and the Nurse Delegation Program.
5. Prescription medications are used only by the individual for whom they are prescribed. Over the counter (OTC) medications are issued to or retrieved by an individual from his/her own supply in accordance with the Nurse Delegation Program.
6. Each prescription medication which is identifiable up to the point of administration. Identifiable means that it is clearly labeled with the name of the individual, name of the medication, and the specific dosage. Prescription medication labels state the expiration date. Names of medications on labels match the Medication Administration Record.
7. All medication errors and reactions to medications are recorded and reported in accordance with written policy, the Community Incident Prevention and Management System (IPMS) Guidelines, and the Nurse Delegation Program.
8. Documentation of corrective action taken regarding medication errors, is maintained by the agency for five years.
9. Discontinued and outdated medications are promptly disposed of in a safe manner. Disposal can be implemented only by a nurse, pharmacist, or physician and must be witnessed and documented in accordance with policy.
10. Each individual who receives medication receives medical supervision by the prescribing physician, to include regular evaluation of the individual's response to the medication.
11. Individuals receiving psychotropic medication are seen and evaluated by a licensed physician, preferably a psychiatrist, at intervals not to exceed a six (6) month period. Reviews of the use of psychotropic medications for each individual are conducted by a licensed physician to ensure the drug is effective, is being given at the lowest possible dosage and is consistent with appropriate standards of care.
    a. Factors/criteria to be taken into account for consideration of psychotropic medication reduction(s), are identified, assessed, and documented. Potential reduction of the psychotropic medication is discussed with the physician and documented and may only be ordered by a physician.
    b. Blood level examinations for individuals receiving anti-convulsant and psychotropic drugs are repeated as often as clinically indicated for potential toxic side effects and to ensure levels are within therapeutic range. Results of most recent blood level examinations are maintained in any organization in which medications are administered. In the event a copy of blood work cannot be obtained, a letter from the physician stating the individual is in his usual state of health is adequate.
12. Individuals may administer their own medication when all the following have been established and documented in accordance with regulations of the Nurse Delegation Program:

a. The individual has been provided with information regarding the purpose, dosage, time, and possible side effects of the medication and has verbalized/effectively communicated understanding.
a. The individual has been instructed regarding what to do and who to call if a dose is missed, if extra medication is taken, or if adverse reaction is experienced and has verbalized/effectively communicated this understanding.
b. The individual has been educated in the maintenance of his/her own medication history and in the recording of information needed by the physician to determine medication and dosage effectiveness. The individual has verbalized/effectively communicated understanding and can perform a competent return demonstration of self-administration of medication.

13. Medication utilized by an individual for self-administration is not locked away from him/her. However, it is secured out of reach of other individuals who have not been determined to be capable of self-administering his/her own medication.
14. Self-medication desire and safety is discussed during the individual's annual Person-Centered Plan meeting and any concerns noted in this area are addressed and documented.
15. The organization supports self-administration of medication through periodic monitoring of administration and documentation of continued proficiency by the individual.
16. For residential and day services, there is a Medication Assistance Supervising (MAS) trained registered nurse or licensed practical nurse as a full-time or part-time employee or consultant to the provider responsible for supervision of delegation of medication assistance to the unlicensed personnel.
17. In residential services, access to an on-call MAS nurse must be available twenty-four (24) hours a day, seven (7) days a week.

6.3.g. Safe Environments

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30, Administrative Code 580-3-22
Effective: October 1, 2020
Revised: March 26, 2021
Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of safe environments.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Procedures:
All environments must be designed and maintained to be accessible, safe, and sanitary for individuals.

A. The Organization Provides Individualized Safety Supports.

1. Safety supports within an environment are available to the extent they are needed, based on a required functional assessment.
2. Assessment includes, but is not limited to, safety in the kitchen, ability to adjust hot water, ability to evacuate in the event of fire or severe weather, call for help, use cleaning supplies, and other safety concerns specific to the individual or the particular living environment.

3. Assessment results are documented.

B. The Physical Environment Promotes Individual's Health, Safety, and Independence.

1. Kitchen areas, electrical appliances, and outlets are free of any unnecessary hazards.
2. The organization assures the building temperature is comfortable for individuals served, according to weather conditions (a normal comfort range in most instances is defined as not going below a temperature of 70-F or exceeding a temperature of 80-F).
3. Environments are clean, pest free, and adequately maintained to ensure basic safety.

C. The Organization has Individualized Emergency Plans.

1. Organizations have emergency plans to deal with a variety of situations and accommodate the specific needs of each individual.
2. Appropriate visual signs and alarms are in place for individuals who need them.
3. Quarterly severe weather drills and monthly fire drills are conducted, documented, and available.
4. Emergency contact numbers are readily available and accessible to staff and individuals receiving supports.

D. Routine Inspections Ensure Environments are Sanitary and Hazard Free.

1. The organization monitors housekeeping, conducts regular safety inspections, and completes routine maintenance and repairs to ensure safe conditions throughout any physical structures. A system is in place to immediately report and correct environmental or safety hazards.
2. The organization maintains records of repairs and maintenance work and of internal inspections to ensure safety and sanitation. Indoor air pollution, inadequate heating and sanitation, structural problems, electrical and fire hazards and older homes with lead-based paint hazards must be addressed in the agency's monthly environmental rounds safety program.
3. Each organization adheres to the applicable certification and licensure standards, statutes, and regulations regarding the physical environment as required by the Alabama DMH Administrative Code Chapter 580-3-22 Minimum Standards for Physical Facilities.
4. The organization maintains the appearance of the setting, inside and out, consistent with that of other settings in the neighborhood. This rule applies to Home and Community Based Services (HCBS) and settings.

6.3.h. Staff Resources and Supports

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30
Effective: October 1, 2020
Revised: March 26, 2021
Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of staff resources and supports.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Procedures:

A. The Organization Implements a System for Staff Recruitment and Retention.

1. The organization will recruit and hire staff in accordance with all applicable laws and organizational requirements.
2. All employees/agents will have references and background checks prior to employment. A national background check is required. Volunteers who work unsupervised with individuals receiving supports will be subject to the aforementioned background check.
3. Background checks must consist of the following personal identifiers; name, social security number, date of birth, and driver's license or state issued non-driver's identification. The following criminal activities will permanently disqualify a potential employee from employment;
    a. Convictions for any crime of violence
    b. Convictions for any felony
    c. The following criminal convictions will prevent a potential employee from employment for the time specified.
        i. Reckless endangerment in the past five (5) years
        ii. Stalking in the second degree in the past five (5) years
        iii. Criminal trespassing in the first degree in the past five (5) years
        iv. Violating a protective order in the past three (3) years
        v. Unlawful contact in the first degree in the past (3) years
        vi. Unlawful contact in the second degree in the past year
        vii. Criminal mischief in the first degree in the past seven (7) years
4. The organization will complete pre-employment drug screening for each employee whose job duties involve the care, safety, and well-being of individuals, and on reasonable suspicion, for cause, of any employee of the organization.
5. The organization will require all new staff that have direct contact with individuals supported to have a TB skin test with documented results, unless there is written evidence that such testing has been done within the last year unless there is a medical contraindication. The TB testing must be administered, read and documented by healthcare professionals who are not employees of the Direct Service Provider.
6. Annual TB testing of employees is not a requirement; however, the organization will annually provide documented ADMH approved TB education training for each employee who has direct contact with the individuals served. This annual education can be completed by healthcare professionals who are employees of the Direct Service Provider.
7. The organization will assess, at least annually, and adjust hiring practices based on analysis of position turnover, availability of qualified candidates, vacancy rates, staffing ratios, availability of financial resources, supports needed by individuals and other relevant data.
8. The organization will work with state and local resources such as schools and job placement services to ensure an adequate supply of qualified candidates.
9. The organization will conduct employee satisfaction surveys, including exit surveys when employees leave.
10. Satisfaction surveys will be reviewed for suggestions to improve recruitment and retention.

B. The Organization Implements Policies and Procedures That Promote Continuity and Consistency of Staff.

1. The organization will have an adequate number of personnel and staff to carry out the stated purpose/mission

2. Individuals supported will have adequate staff to provide needed services and supports so expectations, needs, and desired outcomes can be achieved.
3. The organization will maintain records demonstrating staff accountability.
4. The organization will maintain records demonstrating staff assignments and/or staff schedules.
5. The organization's hiring practices, and staffing plan will be shaped by supports needed by, and individualized for, those receiving services.

C. Staff are Qualified for Their Roles.

1. Employees who directly provide supports to individuals will be at least 18 years of age and have the educational background and licensing credentials as required by the funding source, state law, and federal law.
   a. Residential care direct support employees will have a minimum of a high school diploma or GED/High School Equivalency Certificate.
   b. Personal care direct support employees must be able to read and write and follow instructions.
   c. Respite care direct support employees must have at least completed tenth grade and must be able to read and write and follow instructions.
   d. Day habilitation direct support employees must be able to read and write and follow instructions
   e. Adult companion services direct support employees must have the ability to read and write and follow instructions.
2. Executive Directors/Owners/Operators will possess a bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field working with individuals with various disabilities or have a current Registered Nurse's license. The executive director will have considerable experience (5 or more years) working with individuals with intellectual and/or developmental disabilities in community settings. The director must possess, or be eligible for, license or certification in their particular field if applicable.
3. Support Coordinators at minimum, have a Bachelor of Arts or a Bachelor of Science degree, preferably in a human services related field or social work program with specialized training and a four year college degree and will complete a Support Coordinator training program approved by the ADMH/DDD and the Alabama Medicaid Agency.
4. All Qualified Developmental Disabilities Professionals (QDDP) will have the minimum educational background required, Doctor of Medicine or osteopathy, registered nurse, or a bachelor's degree, in a human service field or a bachelor's degree with 12 hours course credit in a human services field.
5. All QDDPs will have at least one year of experience working directly with individuals with intellectual or other developmental disabilities and will complete QDDP training offered by the state.
6. Students completing a degree in psychology, counseling, social work or psychiatric nursing, will provide direct services only under the following conditions: the student is in a clinical practicum that is part of an officially sanctioned academic curriculum; receives a minimum of one hour/week direct clinical supervision from a licensed/certified mental health professional with at least 2 years post master's experience in a direct service functional area; and the student's clinical notes are co-signed by the supervisor.

The organization will ensure employees maintain current certifications and licenses as required.

D. The Organization Implements an Ongoing Staff Development Program.

1. The organization will assure orientation/training for each employee.
2. The organization will maintain records documenting all employees training on site.
3. Prior to assuming their assigned positions, all employees will complete training in each of the following areas:
    - Rights of individuals served
    - Complaint/grievance procedure
    - Policies and procedures regarding abuse, neglect, mistreatment and exploitation
    - Overview of intellectual/developmental disabilities
    - Infection control/universal precautions
    - Severe weather preparedness
    - Fire Safety
4. Prior to working alone, and within at least 90 days of employment, all employees who provide direct supports to individuals will receive training in:
    - CPR (must receive certification)
    - First aid (must receive certification)
    - Medical emergencies
    - Management of aggressive behavior
    - Medication training including medication side effects
    - Signs and symptoms of illness
    - Incident identification/reporting in accordance with the IPMS
5. Prior to working alone, and within 90 days of employment, all staff who provide direct supports will receive training needed to implement individuals' plans.
6. Within 90 days of employment, all staff who provide direct supports to individuals will receive training in each of the following:
    - Agency policy and procedures
    - Philosophy of self-determination
    - Person-centered supports
    - General behavioral principles with emphasis on skill acquisition and behavior reduction techniques
7. The organization will annually provide refresher training for all employees in each of the following areas:
    - Rights of individuals served
    - Complaint/grievance procedure
    - Policy and procedures on abuse, neglect, mistreatment and exploitation
    - Infection control/universal precautions
8. All direct support staff will be provided annual training in management of aggressive behavior.
9. Medication Assistant Certified (MAC) trained employees will be evaluated in compliance with the Nurse Delegation Program.

10. The staff training program will be developed based on input from individuals supported and their families/legally authorized representatives
11. Staff training will reflect current best practices
12. Training for staff will include one or more of the following:
    - Mentoring
    - On the job support
    - Personal growth and development planning or Competency based measurement
13. All employees who provide direct supports will maintain current certifications in CPR and First Aid.

6.3.i. Positive Services and Supports

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30
Effective: October 1, 2020
Revised: March 26, 2021
Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of positive services and supports.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services
Definitions: Behavioral Services Procedural Guidelines (BSPG)- Provides information and guidance for developing and implementing behavioral services for individuals.
Psychological and Behavioral Services (PBS) Describes several behavior support procedures and ranks them in terms of their restrictiveness. The PBS is found within the BSPG. Both are referenced in this Operational Guideline.
Procedures:

A. Individuals Are Informed About the Services and Supports the Agency Provides.

1. The agency will discuss with the individual receiving supports and the legally authorized representative the organization's services and any related charges, including any limitations placed on the duration or services.
2. The agency will provide a written statement of services and related charges to every individual receiving supports and the legally authorized representative.
3. Individuals responsible for payment of charges for services must be informed of any changes in services or limitations placed on duration of services prior to their occurrence during the service relationship.
4. The information must be provided to the individual in language and terms appropriate to the individual ability to understand.

B. Individuals Are Provided Assistance in Making Choices and Planning for Services and Supports.

1. Each individual will have a support team that includes:
    a. a Qualified Developmental Disabilities Professional (QDDP)
    b. the legally authorized representative or advocate as needed,
    c. family members (as desired by the individual and/or legally authorized representative),

d. representatives of all service providers (particularly staff responsible for program implementation),
e. Support Coordinator, and
f. others as indicated by the individual's life situation, needs, desires, and age (in the case of children), or as requested by the Individual or determined to be of important support.

2. When individuals enter the program, the QDDP will share pertinent information regarding the individual's support needs, including medical care, safety concerns, etc. with Support Team members within 24 hours.
3. There must be documentation included in the individual's record of information shared and those attending the initial support team meeting.
4. Within 30 days of entry into the program, the team will meet to develop a Person-Centered Plan.
5. The team will meet at least annually, every 365 days, to review and update the individual's plan.
6. The team will meet at the convenience of the individual and other members of the team to develop the Person-Centered Plan.
7. Each individual and his/her family members, or others with permission of the individual, must be invited to actively participate in Person Centered Plan meetings, including transition or discharge planning.
8. The individual and/or legally authorized representative must be prepared for the Person-Centered Plan meeting by sharing information to be discussed prior to the scheduled meeting, except in the event an emergency meeting is necessary. Information must be presented to the individual in a method, language, and/or terms appropriate for them to understand.

C. The Organization Assesses the Individual's Personal Goals and Priority Services and Supports.

1. Each individual will have a current functional assessment. If the individual is new to the organization's services, the assessment must be completed no later than 30 days after entry into services.
2. The functional assessment must be updated annually in conjunction with the Person-Centered Plan.
3. The assessment will address all the following areas at a minimum:
   a. individual's preferences,
   b. family/home situation,
   c. health needs,
   d. activities of daily living,
   e. vocational needs,
   f. communication skills,
   g. leisure activities,
   h. physical supports, i.e. adaptive equipment, and
   i. social supports

D. Individuals' Plans Lead to Person-Centered and Person--Directed Services and Supports.

1. Individuals will have Person Centered Plans based on their strengths, interests, and needs.

2. Person Centered Plans will focus not only on skills and supports available to the individual but on those are preferred by the Individual or needed to realize Individual goals as documented in the functional assessment.
3. Person Centered Plans will include learning, participation and support opportunities that are meaningful, functional, and enhance the Individual's dignity.
4. Information for Person Centered Plans must be obtained directly from the individual to the greatest
extent possible or from others who know the Individual best.
5. Information for Person Centered Plans will include observations of the Individual.
6. Person Centered Plans will incorporate information from team members who know the individual well.
7. Person Centered Plans must be modified by individuals with their support teams as needed, as soon as possible when there are significant changes in the Individual's physical or mental condition, and/or when a major life change is being contemplated by the individual or for the individual.
8. The organization will have a clearly defined process for convening special Individual - centered planning meetings. Meetings must be called at any time mutually agreed upon by the Individual and/or advocate or legally authorized representative and his/her team.
9. Person Centered Plans will include prioritized goals designed to achieve desired individualized outcomes. Desired individual outcomes must be defined in such a way that they address the Individual's preferences, are attainable within a specific timeframe and enhance the Individual's life.
10. Goals will include participating in community life, gaining and maintaining satisfying relationships, having opportunities to fulfill respected social roles, expressing preferences and making choices, and continuing the development of Individual competencies.

E. The Organization Provides Continuous and Consistent Services and Supports for Each Individual.

1. All identified formal supports will include implementation strategies defining who is responsible, when, where and how the opportunity is carried out, including the frequency, and methods of data collection to assess achievement.
2. Staff will possess the knowledge, skills and abilities to implement Individuals' Person-Centered Plans as written.
3. Staff will receive training in how to provide or access the supports needed to implement goals in each individual's plan.
4. The organization will provide documented evidence that individuals are offered at least one community integration activity per week.
5. The organization will have a system for ensuring that changes are effectively communicated to everyone within the organization who is important to the Individual or who provides supports to the Individual and ensures appropriate training if any special skills are needed.

F. The Organization Monitors the Effectiveness of Each Individual's Person Centered Plan.

1. The organization will have a system to monitor implementation of Person Centered Plans that include direct observation of services and supports as well as reliable recorded evidence or information that reflects progress toward objectives and achieving desired outcomes.

2. The implementation of Person Centered Plans must be reviewed and documented at least every 90 days for effectiveness.
3. The review will include progress/achievement for each learning, participation, or service opportunity.
4. Person Centered Plans must be modified by individuals with their support team if the individual is not benefiting from identified opportunities or as requested by the individual.

G. The Organization Provides Positive Behavioral Supports to Individuals.

1. Person Centered Plans will include objectives and strategies to address behaviors that interfere with the achievement of individual goals or exercise of individual rights.
2. Strategies to address behaviors will use the least intrusive interventions necessary and the most positively supporting interventions available.
3. When appropriate, individuals will have Behavior Support Plans that reduce, replace, or eliminate specific behaviors.
4. Behavioral Services Procedural Guidelines must be followed when implementing Behavior Support Plans.
5. Behavior supports must be developed by a qualified professional based on information gathered in a functional assessment.
6. Functional assessments will identify physical and environmental issues that need to be addressed to reduce, replace, or eliminate behaviors.
7. Support plans will describe specific behavioral supports that may and may not be used.
8. Behavior Support Plans will include a plan to reach a functionally equivalent behavior that will take the place of a target/inappropriate behavior. BSPG-PBS-02
9. Direct support staff will receive training in behavioral techniques and plans prior to implementation of supports to individuals.
10. The organization will review data related to the effectiveness of behavior supports. The data is reviewed at least quarterly, or more often as required by individual needs.
11. Quarterly reports will summarize the behavioral/psychiatric symptom data. BSPG— PBS-04
12. Data will indicate whether the intervention(s) is effective. BSPG—PBS-04
13. Monitoring will include information explaining why behaviors/symptoms have worsened. BSPG—PBS-04
14. If no progress is made in three months, the Behavior Support Plan must be modified. BSPG—PBS-04
15. The report will include graph(s) of targeted reduction behaviors. BSPG-PBS-04

H. Individuals Are Free from Unnecessary, Intrusive Interventions.

1. Prior to imposing a rights restriction, an assessment must be completed indicating the need for the restriction. The Individual will meet with the support team to discuss the reason for the proposed restriction, except in extreme emergencies to prevent the individual from harming self or others.
2. Criteria for removing the restriction must be developed and shared with the individual, and legally authorized representative, prior to imposing the restriction.
3. The individual, or the legally authorized representative, will give informed consent for any Behavior Support Plan that includes Level 2 or greater procedures.

4. Behavior Support Plan that include Level 2 or 3 interventions must be reviewed and approved by the Behavior Program Review Committee, the Human Rights Committee, and the individual, or the individual's legally authorized representative.
5. All reviews and approvals must be updated annually. BSPG PBS-03
6. Emergency or unplanned behavior interventions that are highly intrusive, level 3, will not be used more than three times in a six-month period without a team meeting to determine needed changes in the individual's Behavior Support Plan.
7. If Individuals require behavioral or medical supports to prevent harm to themselves or others, supports must be provided in accordance with DDD-PBS 01-05.
8. Restraint devices and other restraint procedures will only be applied by staff with demonstrated competency for the device/ procedure.
9. The organization will ensure individuals are not subjected to highly intrusive behavior interventions or punishment for the convenience of staff, or in lieu of a Behavior Support Plan.
10. The organization will prohibit the use of corporal punishment, seclusion, noxious or aversive stimuli, forced exercise, or denial of food or liquids that are part of an individual's nutritionally adequate diet.
11. Requests for the use of Level 4 intervention procedures, except for Emergency Mechanical Restraint, must be sent to the Director of Psychological and Behavioral Services for the Division of Developmental Disabilities after reviews have been completed by the Behavior Program Review Committee, Human Rights Committee, and the legally authorized representative. All restraints approved through the BSP process must be documented in the Person-Centered Plan. The QDDP will review at the frequency directed by the Director of Psychological and Behavioral Services.
12. The agency will document and comply with the limit for use of Emergency Mechanical Restraint as required by the IPMS.

I. The Organization Treats Individuals with Psychotropic Medications for Mental Health Needs Consistent with Standards of Care.

1. The use of psychotropic medications for behavior support and use of medication to reduce or change behaviors associated with psychiatric symptoms will comply with provisions of DDD PBS Level 3, including incorporation into a Behavior Support and/or Psychotropic Medication Plan.
2. PRN orders for psychotropic medications must be administered in accordance with Nurse Delegation Program and in compliance with emergency procedures and due process.
3. The individual's Support Team will meet to assess and address behavioral and psychiatric needs when PRN medications are used as an emergency procedure three times within a six-month period.
4. If an individual has a Psychotropic Medication Plan because they receive psychotropic medication(s) and have not exhibited a targeted behavior in six months, the Psychotropic Medication Plan must be reviewed and approved by the Behavior Program Review Committee at least annually. BSPG—PBS-03

6.3 j. Continuity and Personal Security

Responsible Office: Quality and Planning/Certification

Reference: Administrative Code 580-5-30

Revised: March 26, 2021

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of continuity and personal security.

Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices

Procedures:

A. The Governing Body Provides Leadership.

1. Each organization will have a Governing Body which maintains and has the following documents/information available for review onsite:
    a. written board approved operational policies
    b. articles of incorporation (or a charter) with bylaws
    c. a current organizational chart that is updated regularly, but at least annually, and identifies the titles of employees
    d. a written mission statement approved by the Board of Directors
2. Responsibilities of the board must be defined in writing.
3. Records/minutes of Board meetings will be maintained and available for review.
4. The Executive Director will be responsible for the overall operation of the agency. This responsibility will be included in the job description for the Executive Director
5. The organization will have a written mission statement consistent with its legal constituting documents describing its purpose, services/supports it provides, who receives services, and how expectations of those who receive services and supports are met.
6. The mission and values statement will clearly reflect the organization's commitment to protect individuals' rights.
7. The mission and values statement will reflect the organization's provision and availability of services through positive approaches that are dignified, respectful, and demonstrate achievement of outcomes unique to each individual.
8. The board will review the mission and values statements on a regular basis, but at least annually.
9. A system will be in place for receiving input from current and prospective service users in development of the organization's mission statement, values, and its ongoing organization and operations, as well as the opportunity to provide feedback to participants for required or desired changes
10. The system for providing input or feedback will be developed and maintained in a form that is easily used and understood by individuals receiving services and supports.
11. The organization will conduct flexible operations that meet individual needs in terms of accessibility and availability for those receiving services and supports.
12. The organization will maintain current certifications and licenses for operations and comply with all posting and notification requirements of local, state, and federal offices.

B. The Organization Supports Individuals to Manage and Access Their Personal Money.

1. The organization will refrain from engaging in accounting/ fiscal practices that restrict individuals from having access to their personal money.
2. The organization will, when assisting individuals with money management, provide the

individual, legally authorized representative, and others identified by the individual with documented financial statements of all expenditures and excess funds at least quarterly.

C. The Cumulative Record of Personal Information Promotes Continuity of Services.

1. The organization will maintain a cumulative record of information and documentation of services and supports needed by and provided to individuals.
2. The organization will have:
    a. a system for protecting the confidentiality of records, including financial and health information, in accordance with HIPAA regulations and other applicable state and federal laws.
    b. a system to ensure only those directly involved in an individual's care, or involved in authorized administrative review or service monitoring have access to records
    c. a system for ensuring records are safe from loss, destruction, or use by unauthorized persons.
3. The organization will ensure that birth certificates, Social Security cards, eligibility paperwork, and other legal documents are maintained permanently, and all other records are maintained for five years
4. The organization will ensure the individual's current record includes at least 12 consecutive months of information.
5. The organization will ensure personal information includes only information needed to provide services and supports to individuals.
6. The organization will ensure personal information contained in the record is accurate and legible.
7. The organization will ensure information is organized so it is accessible and able to be updated on a regular basis.
8. The organization will ensure individuals and their legally authorized representative have access to all individual information in their record and is able contribute to the information if they choose to do so.

6.3.k. Quality Improvement System

Responsible Office: Quality and Planning/Certification

Reference: Administrative Code 580-5-30

Effective: October 1, 2020

Revised: March 26, 2021

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of a quality improvement system.

Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.

Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central Regional Offices

Procedures:

A. The Organization Monitors Quality Improvement.

1. The organization will have a written internal monitoring plan approved by their board of directors annually and will be available for review by designated DDD staff.
2. The internal monitoring system will measure the most important elements and key functions of the organization.
3. The organization will monitor, at a minimum, the following areas:

a. Promotion and protection of individual rights.
b. Dignity and respect practices.
c. Promotion of natural supports.
d. Protection from abuse, neglect, mistreatment, and exploitation, including implementation of an incident prevention and management system.
e. Best possible health, including implementation of the Nurse Delegation Program.
f. Safe environments.
g. Staff resources and supports.
h. Positive services and supports, including implementation of the Behavioral Services Procedural Guidelines.
i. Continuity and personal security.

B. A Comprehensive Plan Describes the Methods and Procedures for Monitoring Quality Improvement.

1. The organization will clearly identify data sources, methods for data collection and the type of data analysis to be performed for each function measured.
2. The organization will identify individuals responsible for collecting and analyzing data from the internal monitoring system.
3. The organization will identify responsibilities and roles of each individual involved on the internal monitoring team and include individuals supported.

C. Quality Improvement Monitoring Data is Used for Continuous Learning and Development.

1. The internal monitoring system will emphasize quality enhancement and continuous improvement.
2. Data collected, and information learned from the internal monitoring system will be used to inform and educate staff and individuals receiving services, improve systems, and ensure quality improvement is met

6.3.I. Personal Care, Companion Care, Respite Care Crisis Intervention Services, and Supported Employment at an Integrated Worksite

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30
Effective: October 1, 2020
Revised: March 26, 2021
Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of personal care, companion care, respite care crisis intervention services, and supported employment at an integrated worksite.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices; HCBS Waivers: ID, LAH
Definition: EVV (Electronic Visit Verification)
Procedures:

A. Staff Providing Services Know How to Support the Individual.

1. In addition to administrative requirements in Chapter 580-5-30-.10, the organization will provide training to staff on the services to be provided and how the individual wants to be supported. This training will include:
    a. Review of the Person-Centered Plan.
    b. Information about specific conditions and required supports of the individual to be served, including his/her physical, psychological or behavioral challenges, his/her capabilities, and his/her support needs and preferences related to that support.
    c. Reporting and record keeping requirements.
2. The organization will provide procedures for arranging backup workers when needed.

B. The Organization Develops and Implements a Person-Centered Plan.

1. A Person-Centered Plan will be developed and approved for the individual receiving services, and there is documentation establishing that the plan is followed and is modified as needed.
2. The Person-Centered Plan will be adequately detailed so the worker can provide the services required by the individual.
3. The Person-Centered Plan will be approved by the Division of Developmental Disabilities. If services exceed twelve (12) hours per day of services, documentation must support the need.
4. If providing respite services, the organization will provide evidence that a temporary support plan was developed prior to the service and is documented and implemented for the individual while served by the organization.
5. The Person-Centered Plan will be developed with input from the individual, their legally authorized representative, family, and/or advocate.
6. If the individual's needs require more than twelve (12) hours of personal care or companion service per day, the individual and his/her team will meet to discuss a viable alternative service which will meet his/her needs.
7. If the individual and his/her team decides personal care, companion, respite, and/or crisis intervention services are no longer adequate, a viable alternative service will be located prior to discharge.

C. Services Are Monitored

1. Documentation of the provision of identified services/supports will be available.
2. A QDDP will be assigned to supervise the provision of personal care, companion, respite and crisis intervention services to the individual, evaluate the continued appropriateness of such services, and makes changes when the individual's needs or desires are not being met.
3. The QDDP will conduct a site visit at least every ninety (90) days, and more often if needed. For Personal Care and Companion Care, QDDP on-site supervision must occur at least every 60 days, to include the required supervisory EVV log-in.
4. The QDDP will assess the effectiveness of the service, individual/family satisfaction with the service, and institutes any changes that are needed.
5. Documentation will be made establishing that the QDDP has taken corrective or improvement action in a timely manner, as need indicates.

6.4. Incident Prevention and Management System (IPMS)

Responsible Office: Quality and Planning/Certification
Reference: Alabama Administrative Code 580-5-30
Effective: December 1, 2020
Statement: Incident management serves to promote an environment free from harm. The Division is committed to the following beliefs:

- People are entitled to appropriate services in a caring environment that promotes dignity, respect, and is free from harm.
- Providers must eliminate, wherever possible, the occurrence of preventable incidents and respond appropriately to all types of incidents.
- The fewer the number of incidents, particularly serious incidents, the more caring the environment will be for people to live, work, and learn there.

In 2016, ADMH adopted THERAP Services, a web-based service organization that provides a solution for documentation, communication, and incident reporting needs for agencies providing support to people with DD. DDD providers use this tool to submit reportable incidents to RCS offices, and other appropriate entities. In THERAP, reportable incidents are referred to as General Event Reports (GER), and completed investigations are referred to as GER Resolutions.

Revisions to the IPMS Manual were made in response to the joint report issued by the U.S. Department of Health and Human Services, Office of Inspector General (OIG), the Administration for Community Living (ACL), and the Office for Civil Rights (OCR) which required increased oversight to improve health and safety of people receiving waiver services. (See Exhibit 6.4 for full manual)
Purpose/Intent: To protect the program integrity and demonstrate financial accountability. The purpose of the community Incident Prevention and Management System (IPMS) is to describe and implement through standard actions by the Division of Developmental Disability Services, its Regional Community Services (RCS) offices, and contractors, a mechanism to protect persons served from harm, and improve the oversight and response capabilities of the systems that serve them. Protection from harm requires an incident management component that includes prevention, identification, classification, proper reporting and investigation, and implementation of effective actions to remedy situations that lead to harm.
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions: An incident is any unplanned occurrence that has the potential to affect the health, safety, and welfare of persons served by the DDD.

Pursuant to the IPMS, the following are considered reportable incidents: medical emergencies including moderate injuries, severe injuries, choking, seizures, falls, and unscheduled hospital admissions, medication errors, AWOL/Missing person, death, behavioral issues, natural disasters, fire, allegations of abuse, neglect, mistreatment, or exploitation, physical assault, sexual assault, manual restraint, mechanical restraint, chemical restraint, and other occurrences which require the notification of Police, or DHR.

Critical incidents are events that create significant risk of substantial harm to the physical or mental health of waiver participants. Critical incidents requiring a major level of review generally include deaths, physical and sexual abuse or sexual assault, neglect, exploitation, suicide attempts, unscheduled hospital admissions, severe or moderate injuries, Level 3 medication errors and AWOL/Missing persons reports. Critical incidents requiring a minor level of review generally include verbal abuse, mistreatment and property damage.

Procedures:

All agencies are required to notify ADMH of all reportable incidents and take action in accordance with the Incident Prevention and Management System policy, which includes state law and funding source requirements. Incident reporting, investigations and follow-up processes must be followed as specified in the IPMS guidelines. Consideration must be given to specified timelines for reporting and resolution of incidents and investigations. Full cooperation is expected, including requests from the Bureau of Special Investigations (BSI) and ADMH Advocacy. Failure to submit information or respond to requests may prompt an agency investigation led by ADMH.

All requests by ADMH for information and corrective actions will be made in writing, either through THERAP, email, or certified mail, with a designated response date. Requests by ADMH to obtain information or evidence that corrective action has been implemented will be made to the Executive Director up to three times. Agencies that fail to cooperate with any request for information or corrective action will be subject to an immediate Provisional certification for a specified period. The Provisional certification status will remain in effect until either the requested corrective action is taken, information is provided, or specified certification date has expired. Failure to comply with documentation and/or corrective action requirements may also result in a For Cause certification review. Furthermore, failure to cooperate may result in decertification, termination of ADMH contract, or other enforcement actions due to noncompliance.

CHAPTER 7
BEHAVIORAL SERVICES

7.1 Behavioral Services Procedural Guidelines

Responsible Office: Psychological and Behavioral Services
Reference: ADMH Administrative Code 580-5-30-.02 (2), Behavioral Service Procedural Guidelines: DDD-PBS, HCBS Waivers
Statement: The Behavioral Service Procedural Guidelines were established to provide behavioral services for persons with intellectual disabilities in the state of Alabama. The guidelines were developed by the Behavior Analysis Task Force a group of professionals representing both community providers and the Developmental Disabilities Division of the Department of Mental Health. The guidelines were developed using the principles of Applied Behavior Analysis as the foundation. Behavioral services based upon these principles have resulted in successful skill acquisition and/or behavior reduction for persons with intellectual disabilities. Because of the evidence-based support for the use of a behavior analytic approach to the provision of behavioral services, the state of Alabama Department of Mental Health determined that services based on these principles would provide the best quality for the consumers served.
Purpose/Intent: The purpose of the guidelines is to provide information and guidance for the development and implementation of behavioral services for persons with intellectual disabilities who are receiving services through one of the community agencies contracting with the state Department of Mental Health. The guidelines are intended to supplement the Community Standards used for certification of service agencies.
Scope: These procedures apply to all providers and recipients of behavioral support services though the Alabama Department of Mental Health, Division of Developmental Disabilities.
Definitions: The Behavioral Guidelines describe all of the behavioral training and intervention strategies that are approved for use in the state of Alabama. The term behavioral refers to interventions that focus on actual, measurable, real-world behaviors and outcomes; HRC (Human Rights Committee); BPRC (Behavior Program Review Committee); IDT (Interdisciplinary Team); BSP (Behavior Support Plan)
Procedures:

1. The Behavioral Services Procedural Guidelines outline the minimum requirements for providing behavioral services in the state of Alabama.
2. The Behavioral Services Procedural Guidelines details four levels of procedures in providing an individual with each successive level indicative of greater restrictiveness, such that Level 1 procedures are not restrictive at all and Level 4 is highly restrictive. All level 4 procedures must be approved by the Director of Psychological and Behavioral Services, only after the Person-Centered Plan and BSP have been reviewed by the IDT, individual, HRC, and BPRC.
3. The Behavioral Services Procedural Guidelines require that, for any person prescribed psychotropic or other medications for the purposes of addressing/treating behavioral challenges and/or psychiatric symptoms, a Psychotropic Medication plan be developed for the purposes of ensuring that reductions are considered and implemented wherever possible.

4. Anyone providing behavioral support services, as well as positive behavior supports through ADMH- HCBS waiver services must have received training on the Behavioral Services Guidelines provided by the Office of Psychological and Behavioral Services.
5. The Office of Psychological and Behavioral Services provides the Behavioral Service Procedural Guidelines Training throughout the five ADMH-DD regions.
6. Requests for training can be made through the three Comprehensive Support Teams, as well as through the Director of Psychological and Behavioral Services.

7.1.a. Behavior Support Plan Writing and Content

Responsible Office: Psychological and Behavioral Services
Reference: ADMH Administrative Code 580-5-30; Behavioral Services Procedural Guidelines: DDD-PBS, HCBS Waiver Manual
Effective: April 1, 2021
Statement: An individual receiving HCBS waiver services from the Alabama Department of Mental Health, Developmental Disabilities Division, is required to be provided with a Person- Centered Plan of services, which could include a Behavior Support Plan where applicable.
Purpose/Intent: To provide content required specific to a Behavior Support Plan, which will assist in the efficacious provision of Positive Behavior Supports.
Scope: DDD HCBS Waiver Service Providers, Support Coordinator Services, ADMH-DDD Central/Regional Offices
Definitions:
Behavior Support Plan- also referred to as a BSP is a plan that assists an individual in building positive behaviors to replace or reduce challenging/dangerous behavior(s).
Behavior- defined as any observable and measurable act of an individual, bad or good.
Target behavior- defined as the undesirable or maladaptive behavior to be changed. The target behavior should be defined in specific and objective terms.
Functional Behavior Assessment- an assessment that identifies observable and measurable, operationally-defined behaviors of concern; identifies events and situations which predict when the target behavior will and will not occur; and identifies what functions the behaviors appear to serve as well as outlines replacement behaviors.
Procedures:

1. The Behavioral Services Procedural Guidelines require that, for any person exhibiting behaviors that interfere with the implementation of the Person-Centered Plan, a BSP must be designed and implemented to:
    a. Reduce those undesirable behaviors
    b. Describe needed alterations to the environment to reduce or remove triggers to undesirable behaviors
    c. Describe procedures to promote and encourage existing desirable behaviors
    d. Teach new acceptable behaviors that are effective to obtain desired outcomes for the person involved
    e. Describe procedures to be used by staff to respond to dangerous or undesired behaviors when they occur
2. The BSP should provide clear descriptions of behaviors of concern and explicit instructions to staff on the actions they are to take to provide training, reinforce desired behaviors, modify the

environment, respond to target behaviors, and tabulate data. A copy of the data sheet(s) to be used in carrying out the BSP should be included as part of the instructions for the BSP.

3. The BSP consists not only of the written plan but also its implementation.
4. There should be evidence of staff training and competence in carrying out the BSP.
5. Implementation of the BSP must demonstrate adequacy of the measurement method, including tabulation on forms that promote accuracy in recording and guidance to staff regarding the procedures used to count behaviors. A copy of the data sheets used in carrying out the BSP should be included as part of the instructions for BSP. The data recording form is considered a component of the BSP, and training in its use is a part of the implementation.
6. During implementation of the BSP, decisions regarding treatment effectiveness and the need for changes in treatment are made. Data must be presented and be adequate to justify the inferences drawn from them.
7. CONTENT- The BSP must include:
    a. Demographic and operational information
        i. Name, date of birth, and age of the individual
        ii. Author(s) of the plan and supervising BCBA if applicable
        iii. Date of implementation of the plan
        iv. Restriction level of the plan and listing of all restrictions
    b. The goal or purpose of the BSP (e.g., reduce hitting of others, running away from staff, and refusing medications; teach requesting reinforcers, waiting in line at store check-out, brushing teeth)
    c. Historical information
    Information relevant to current behaviors, including prior behavioral strategies and their outcome. Include prior restrictive interventions if applicable.
    d. Diagnostic information
    All diagnoses, psychiatric, cognitive, and medical (e.g., autism, ID, anxiety, genetic disorders, etc.)
    e. Medications
    Psychotropic and non-psychotropic medications with name of medication, dosage, and associated diagnosis and symptoms
    f. Target Behaviors
        i. Define each behavior of concern in terms that can be recognized when they occur
        ii. If applicable, describe observable behaviors that indicate a psychiatric event is occurring (e.g., staring into a dark corner and speaking to the corner) and the method(s) for counting them when they happen.
        iii. Include 12 months of data if available; specify type of data collection (e.g., average number of occurrences per hour, graphed by average per day; daily average number of 15-minute intervals within which the behavior occurred, etc)
    g. A summary of the Functional Behavior Assessment, the hypothesized functions of target behaviors, and strategies to deal with them. List the source of information (direct observation, staff interview), describe settings, antecedents of behaviors, and maintaining factors.

h. Behavioral goals: Describe measurable goals for learning desirable behaviors and methods to be used to teach them and measurable goals and teaching strategies for reduction of undesirable behaviors.
    i. Descriptions of antecedent modifications. Strategies that include reinforcement, changes to the environment, teaching of replacement behaviors, that make desired behaviors more likely and undesirable behaviors less likely.
    ii. A description of the replacement goals for each targeted behavior.
    iii. Specific procedures for staff to follow when target behaviors and crisis situations occur.
i. The supports needed to implement the procedures outlined.
j. Listing of all restrictive procedures:
    i. Name of the procedure
    ii. Level of restriction
    iii. Justification for inclusion in the BSP
    iv. Brief description of previous and current efforts to fade restrictive interventions
k. Data collection methods and monitoring of the plan
    i. How staff will collect data both for target behaviors and for training
    ii. Who will monitor the plan and when
l. Methods for staff competency training and monitoring of program implementation
m. Due process safeguards. Signatures of:
    - Individual served
    - Guardian (if applicable)
    - Plan author
    - BCBA supervising the Plan
    - BPRC review and approval
    - HRC Review and approval

7.2. Request for Action for Special Level of Staffing Restrictions

Responsible Office: Regional Community Services
Revised: October 16, 2020
Statement: Special level of staffing is a restriction requested via the Request for Action process that must be justified with data and documentation and managed as per Behavioral Guidelines.
Purpose/Intent: As an intrusive restriction, special level of staffing must be requested in accompaniment with, at a minimum, relevant target behavior data, Behavior Support Plans, and review/rationale from the person's interdisciplinary team.
Scope: Regional Community Services; Fiscal Manager; Service Coordinators; Providers
Definitions: Regional Community Services (RCS); RFA (Request for Action); Community Services Specialist (CSS); GER (General Event Report); BSP (Behavior Support Plan); IRBI (Individual Residential Budgeting Instrument); DDD IMS (Division of Developmental Disabilities Information Management System
Procedures:

1. If a person served requires a special level of staffing restriction, the Provider submits to the Support Coordinator a Request for Action (RFA) detailing the special level of staffing restriction requested and provides (at minimum) the following documentation:
    a. If requesting supports for behavioral concerns:
        i. Current Behavior Support Plan, including a realistic and attainable plan for fading of special level of staffing restriction and all required approvals
        ii. Target behavior frequency data in line graph format (as applicable) for the previous three (3) months (if an initial restriction) or for the previous twelve (12) months (if a continuation of a restriction).
            - Data on fading periods (if applicable)
            - When the Behavior Support Plan utilizes any type of protective equipment as a means to reduce behavior, data will be submitted on the use of protective equipment (i.e. number of times used and duration of application)
            - When staffing is utilized 24 hours/day, data will be submitted on hours slept per night and behaviors that occur during overnight hours separate from behavior frequency data
            - The most recent Quarterly Support Coordinator Summary
        iii. Interdisciplinary team note reflecting:
            - Review of necessity of continuing special level of staffing restriction
            - Rationale for continuing special level of staffing restriction, if continued
            - Review of the effectiveness of the BSP
            - Review of progress on alternatives to targeted behaviors justifying the use of special level of staffing
            - Recommendations for modifying the BSP to better address target behavior(s) warranting the special restriction, if deemed ineffective at reducing frequency(s) of target behaviors
    b. If requesting supports for medical concerns:
        i. Detail of supports individual requires due to medical status

ii. Most recent physical/medical assessment
iii. Current status (i.e. progression, regression, or no change)

2. The Support Coordinator uploads these documents to DDD IMS Notes and tags designated RCS staff responsible for managing RFA's.
3. RCS reviews the RFA and associated documentation for completeness and compliance with Behavioral Guidelines.
4. If questions or incomplete/insufficient documentation, RCS responds to the Support Coordinator to request additional information.
5. The Support Coordinator communicates with the Provider to obtain the requested information.
6. When providers do not provide documentation to substantiate the need for a staff-involved restriction (e.g., special level of staffing), RCS cannot authorize billing based on an IRBI that reflects that special level of staffing.
    a. When this occurs, RCS will offer non-compliant providers the option of submitting an IRBI updated to reflect standard level of staffing for persons for which special level of staffing documentation has not been adequately submitted. Thus, they may bill uninterrupted and may then later back-bill for the difference in the special level of staffing rate once they come into compliance.
7. Upon receipt of all available/requested information and within seven (7) working days, RCS makes a determination based on individual progress and factors in data/BSP (e.g., data trends, fading criteria, etc.) and on Behavioral Guidelines.
8. A final determination is communicated to the Support Coordinator via DDD IMS Notes.
9. The Support Coordinator communicates this determination to the Provider within three (3) working days.

7.3. Comprehensive Support Systems (CSS) Teams

Responsible Office: Psychological and Behavioral Services
Reference: ADMH Administrative Code 580-5-30-.02 (2); ADMH Policy 540-1
Statement: The Alabama DMH Division of Developmental Disabilities (DD) provides a comprehensive array of specialized services for people with intellectual disabilities in the State of Alabama who meet criteria for services through an interdisciplinary treatment modality, utilizing clinical professionals with advanced training in behavioral support services.
Purpose/Intent: The Comprehensive Support Services teams were established to provide consultative assistance to agencies, organizations, and communities to address significantly challenging, crisis, and/or emergency situations that may lead an individual with an intellectual disability to psychiatric hospital admission, incarceration, or difficulty maintaining community placement. Specialized services, consultations, evaluations, and training services are provided in a manner that is designed to increase the capacity and expertise of agency, organization personnel, and/or family serving the individual, as well as to assist the person.
Scope: These procedures apply to all that provide services and supports to people with intellectual and developmental disabilities through ADMH-DD.
Definitions: Individuals Served: Persons who meet the criteria of having an Intellectual disability and present issues which require diagnostic or treatment consultation may be eligible for services provided by the Comprehensive Support Services teams.
Procedures:

1. Comprehensive Support Services teams assess the need for and assist with providing an array of supports to individuals who require specialized services. Additionally, these teams assist providers with developing internal capacity related to these and other specialty areas.
2. The three Comprehensive Support Services teams are located in Decatur, Montgomery, and Mobile, and have offices located in the Regional Community Services offices. The division of responsibilities for state-wide coverage is as follows:
    - Decatur team - provides services for Regions I and upper part of Region II;
    - Montgomery team - provides services for Regions IV and V; and
    - Mobile team - provides services for Region III and lower part of Region II.
3. Comprehensive Support Services team consist of a licensed advanced level psychology professional who serves as the team leader and is responsible for coordinating the development and maintenance of procedures and protocols (standardized across teams) addressing all activities of the team, including the intake process; Master's and Bachelor's level psychological and behavioral services professionals; and, a clinical professional specialized in providing behavioral services to children. CSS will also utilize the services of a Primary Care Physician; a Psychiatrist; a Dentist via contract consultation and part-time employment opportunities.
4. Services Provided:
    a. Training on the Behavioral Services Procedural Guidelines
    b. Consultation regarding individuals with severe behavioral problems
    c. Assistance with developing Behavioral Support Plans, Special Level of Staff Plans, Fading Plans
    d. Activities in the areas of psychiatric consultation services, medical consultation services, and dental services may require the participation of multiple team specialists.

5. Who should be referred:
    a. Person with ID who exhibits challenging behaviors with the potential to escalate into a crisis situation
    b. Medical, psychiatric, or dental services cannot be obtained in the community for the person
    c. Current behavioral or medical treatment strategies are not effective
    d. Numerous psychotropic medications or high doses are prescribed
    e. Person begins exhibiting new problem behavior(s)
    f. Recent psychiatric/behavioral hospitalization(s)
    g. Involvement with law enforcement due to behavioral disturbance
6. Accessing Services: In order to access Comprehensive Support Services, provider agencies and/or families should contact their Regional Community Services Office. The Directors of these offices implement established procedures for processing and prioritizing referrals using the Request for Regional Action procedures.

CHAPTER 8
WAIVER SERVICE GUIDANCE

8.1. IRBIs

8.1.a. For DMH and DHR Funded School Aged Children

Responsible Office: Administrative and Fiscal Operations
Reference: N/A
Statement: Calculating residential rates for school aged children on the ID waiver and matched with DMH or DHR funds
Purpose/Intent: Blended rates of school days and out of school days have been used in the past to calculate an annual IRBI rate. When this is done, and a student's residence changes during the school year, this results in the provider reimbursement being incorrectly reflective of the student's school versus home hours.
Scope: School aged DMH and DHR in residential waiver services
Definitions: IRBI (individualized residential budgeting instrument); DMH (Department of Mental Health); DHR (Department of Human Resources); ID (intellectual disabilities)
Procedures: When calculating residential rates for school aged children you should formulate two IRBIs. One for the school year and one for the summer break. When authorizing these rates for billing purposes the school year calendar of the system the student is attending should be reviewed for school year ending and beginning dates.

8.1.b. Absentee Rates

Responsible Office: Administrative and Fiscal Operations
Reference: N/A
Statement: Calculation of Absentee Rates for the IRBI
Purpose/Intent: To establish eligible dates for calculating individual residential absentee rates.
Scope: This guideline applies to all providers of residential services and fiscal managers representing ADMH/DDD regional offices.
Definitions: IRBI (individualized residential budgeting instrument)
Procedures: Providers are allowed to change existing residential absentee rates on the IRBI once a year in the month of August to be reflected on the authorizations beginning September 1st. Changes in absentee rates should be requested directly to the Fiscal Manager representing the region of the individual's residence.

8.1.c. IRBI Completion and Workflow

Responsible Office: Administrative and Fiscal Operations
Reference: N/A
Revised: May 7, 2021
Statement: Party responsible for completion of IRBI and workflow after completion.
Purpose/Intent: To outline the responsible party for completion of IRBI, technical support available and workflow after completion.
Scope: DDD HCBS Waiver Service Providers

Definitions: IRBI (individualized residential budgeting instrument); DMH (Department of Mental Health); RFA (request for regional action)
Procedures: Residential providers will bear the responsibility of completing IRBIs on people served in residential settings when the individual is placed with the program and when any changes are needed in the IRBI for staffing coverage (to be approved through the RFA process). The IRBI should reflect the individual's needs, as set forth in the person-centered plan. The IRBI should reflect the individual's needs, as set forth in the person-centered plan. If help is needed with completing the IRBI, the provider should contact the Fiscal Manager in their respective regional office. Regional Fiscal Managers will assist in the completion, given the request for staffing needs and absentee rate from the provider. The provider will then complete the IRBI and send it to their Regional Community Services Director. The director will check the IRBI to ensure it aligns with the context of the person-centered plan.

When approved, the IRBI will be scanned into ADIDIS by regional office staff. Support Coordination will be added as a note recipient.

An updated IRBI is required from provider of residential services when any of the following occur:
1. Change in a person's address
2. Change in a person's daily schedule
3. Change in housemate status (change in housemate staffing needs, i.e. 1:1)
4. Change in status of housemate schedule
5. Change in ICAP score

If the IRBI in ADIDIS does not match current approved staffing at redetermination, an updated IRBI should be included with the individual's annual redetermination packet. The IRBI template is posted on the Department's website.

The IRBI will be reviewed, in conjunction with an individual's Person-Centered Plan (PCP), by regional office staff before a site is monitored.

8.2. Provider Recoupment Guidelines

Responsible Office: Administrative and Fiscal Operations
Reference: Administrative Code 580-5-30(.03) 580-5-30-.05 and 580-5-30-.10; DDD IPMS Guidelines 6.4; ADMH Contract
Effective: November 1, 2020
When findings of DDD monitoring, certification reviews, audits, etc. reveal potential improper billings by providers, overpayment and/or unwarranted billings and payments for services, and/or misuse or theft of client funds, the DDD staff shall:

1. Central Office Directors will notify the DDD Associate Commissioner and provide all related documentation and evidence including written report of findings.
2. The DDD Associate Commissioner will review the findings and make a determination if further review and/or investigation are warranted.
3. If the Associate Commissioner determines there is no impropriety and that no further review or investigation is warranted, the Associate Commissioner shall inform the referring DDD staff and ensure that training, technical assistance, etc., as appropriate, is provided to address the findings.
4. If the DDD Associate Commissioner determines that further review and/or investigation is warranted, the Associate Commissioner will refer and request an investigation be conducted by the proper ADMH Officials including, Bureau of Special Investigations (BSI); ADMH Internal Advocacy Office, ADMH Internal Audit Office or other as deemed appropriate. If findings involve potential misuse of federal funds or non-ADMH state funds, such as Medicaid, Social Security, etc., the Associate Commissioner will notify the appropriate agency, provide copies of written findings and inform of referral, if any, to other ADMH Officials for review and investigation.

ADMH Officials including, Bureau of Special Investigations (BSI); ADMH Internal Advocacy Office, ADMH Internal Audit Office or other as deemed appropriate. If findings involve potential misuse of federal funds or non-ADMH state funds, such as Medicaid, Social Security, etc., the Associate Commissioner will notify the appropriate agency, provide copies of written findings and inform of referral, if any, to other ADMH Officials for review and investigation.

8.3. Public Health Emergency

8.3.a. Covid-19 Infectious Disease Emergency Plans for Direct Support Providers

Responsible Office: Administrative and Fiscal Operations
Effective: June 10, 2020
Statement: Direct Service providers must be prepared to serve persons receiving Waiver services during an infectious disease emergency with the utmost accountability to meet the health and safety needs of individuals with Intellectual Disabilities, who are considered "vulnerable persons" by the CDC, due to higher potential for underlying conditions that may place them and the direct support staff who assist them at an increased health risk, particularly as related to COVID-19. Examples include those individuals 65 or older and/or with underlying medical conditions that may increase risk of serious COVID-19 include but are not limited to: Blood Disorders (e.g. sickle cell or on thinners), Chronic Kidney Disease (medication treatment or dialysis), Chronic Liver Disease (cirrhosis, chronic hepatitis), Compromised Immune System (immunosuppression) cancer, chemotherapy/radiation, organ or bone transplant, high doses of corticosteroids or immunosuppressant medication, HIV/AIDS. Endocrine Disorder (diabetes mellitus) Metabolic Disorder (inherited or mitochondrial disorder) Heart Disease (Congenital, congestive or coronary artery disease) Lung Disease (Asthma, chronic obstructive pulmonary disease, bronchitis, emphysema, impaired lung function, or required oxygen), Intellectual Disability, Neurological, neurologic and neurodevelopmental conditions (brain spinal cord disorders, spinal cord injury, peripheral nerve, cerebral palsy, epilepsy, seizures, stroke, moderate to severe developmental delay, muscular dystrophy).
Purpose/Intent: Direct Support agencies will compose and maintain written emergency plans, policies, and procedures to ensure they can successfully implement strategies to mitigate and respond to an outbreak of epidemic/pandemic proportions of an infectious disease (e.g., COVID-19).
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices; Individuals Served
Definitions: Division of Developmental Disabilities (DDD); Regional Community Services (RCS); Community Services Director (CSD); Support Coordination Entities (SCE's); Incident Management & Prevention System (IPMS); Occupational Safety & Health Administration (OSHA); Centers for Disease Control (CDC)
Procedures:

1. All Direct Support Service agencies serving persons receiving Waiver services must compose, maintain and implement an emergency plan for mitigating and responding to epidemic/pandemic outbreaks of infectious disease (e.g., COVID-19). This emergency plan must include, at a minimum, the following elements:
    a. Distinct phases of the Direct Support Service agency activity, dependent upon governmental/public health mandates (e.g., work from home, infection control, social distancing, quarantine, shelter in place, etc.).
    b. Specific changes to Direct Support Service agency operations in each phase, including:
        i. Methods to access necessary records and information for persons receiving Waiver services by oversight and service coordination entities.

ii. Methods for maintaining reliable and consistent communication between RCS, SCE's, persons receiving Waiver services, and families/caregivers.
iii. Methods for communicating emergency plans, and their level of implementation, to persons receiving Waiver services, families/caregivers, SCE's and RCS.
iv. Methods for communicating any changes in staffing ratios as a result of the infectious disease emergency occurring.
v. Methods for communicating with persons receiving Waiver services, SCE's, RCS, and families/caregivers regarding, and acting expeditiously upon, the potential need for emergency services or emergency changes to existing services, should the person, provider, family, caregiver, or other critical supports become unavailable as a result of the infectious disease emergency occurring.
vi. Plan for effectively continuing operations if/when the Direct Support Service agency experiences reduced staffing capacity as a result of staff contraction of the infectious disease.
vii. Screening and Policies (including reporting of positive results and time frames for such) for Employees Exhibiting Signs and Symptoms per CDC guidelines.
viii. Screening and Policies (including reporting of positive results and time frames for such) for Persons Served Exhibiting Signs and Symptoms per CDC guidelines.
ix. Screening and Policies (including reporting of positive results and time frames for such) for anyone (e.g., Department Staff, members of the community, maintenance personnel) entering settings.
x. Notification of Exposure per ADMH directives through IPMS, and other reporting requests, and also in compliance with standards of the federal Health Insurance Portability and Accountability Act (HIPAA).
xi. Full compliance with CDC guidelines relating to safe practices that reduce risk of exposure of the virus by individuals served, staff and family members at a minimum should include the following:
    - ❖ Handwashing and sanitary practices per CDC guidelines to include respiratory etiquette (e.g., covering your cough or sneeze).
    - ❖ Social distancing strategies, per CDC guidelines, to include the following:
        - o Physical environments will be adapted based on square footage and (per ADMH/APDH/CDC guidelines) limitations on group sizes in individual rooms throughout the Center;
        - o Measures to prevent cross contamination (e.g., no rotation of classes);
        - o In-person and large group meetings relating to service coordination and planning;
        - o Administrative function of the entity;
        - o Restrooms;
        - o Meal planning and communal dining; or
        - o Creating more space between work or training stations.
xii. Housekeeping (all settings) – sanitizing and disinfecting, at a minimum, tables, other surfaces, door handles, light switches, bathrooms, vehicles, technology

and equipment (e.g., computers, phones, etc.) and other common touch points throughout the day, using a CDC-approved sanitizer/disinfectant and the frequency these tasks should be accomplish.

xiii. Transportation, public and private, to include social distancing requirements and sanitation practices per CDC guidelines will be accomplished.

xiv. Procedures for identifying and correcting non-compliance with health and safety procedures (e.g., refusal to wear mask during transportation).

xv. Provider requirements for signed assurance statements by and between the agency and individual/family.

xvi. Procurement, distribution and use of personal protective equipment, and the maintenance thereof, according to CDC and OSHA guidelines.

xvii. Managing employment outcomes for people served to include individual risk assessments and employer work environment.

xviii. Collaborative engagement with the person, family, support Team and led by the Support Coordinator, to complete an Individual Risk Assessments for participation in community activities, visitation with family, and day services, etc.

xix. Distinct communications and training plans to mitigate risk so to ensure best possible health and protections of individuals served, families, and staff, to include utilization of communications that best meets the needs and learning styles of individuals served.

2. As circumstances dictate shifting through the phases of the Infectious Disease Emergency Plan, the Direct Support Service agency is to report these changes to the SCE and RCS CSD(s) immediately as they occur.
3. The Infectious Disease Emergency Plan must be composed, updated and implemented within thirty (30) days of the publication of this Operational Guideline, or as mandated by DDD if required during an infectious disease emergency (e.g., COVID-19). Upon completion, it is to be immediately submitted for review/approval to the Community Services Director(s) (CSD's) of the Region(s) in which the Direct Support agency operates.
4. The Infectious Disease Emergency Plan is to be reviewed and updated as new ADMH and/or ADPH/CDC guidelines are released during the pandemic and annually when there is no pandemic. The Infectious Disease Emergency Plan is subject to review by RCS and Certification staff persons to ensure compliance.

8.3.b. Covid-19 Appendix K - Temporary Presumed Eligibility During a State of Emergency

Responsible Office: Waiver Services
Reference: Covid-19 Appendix K
Effective: January 26, 2020
Statement: In times of emergency, persons with intellectual disabilities may be especially vulnerable and in potentially greater need for services but without normal access to documentation/assessments to substantiate eligibility for Waiver services.

Purpose/Intent: When a State of Emergency is declared by the Federal, State, or Local government within whose jurisdiction Waiver services are being delivered, eligibility criteria for Waiver services may be relaxed to ensure timely access to services by persons presumed eligible and in need.

Definitions: Division of Developmental Disabilities (DDD); Regional Community Services (RCS); Community Services Director (CSD)

Procedures:

1. Temporary Presumed Eligibility standards remain in effect until such time as the applicable State of Emergency is lifted.
2. During this period of time, Temporary Presumed Eligibility standards allow for the following practices during determination of eligibility;
    a. Remote eligibility activity – All eligibility activities (including applicant and clinician contact) may be completed remotely. Specifically, in-person activities (such as intakes and interviews) may be completed by phone, or secure telehealth technology, when possible to avoid in-person contact and limit risk of spreading the infectious disease. Additionally, please request all medical records, school records, and other required documentation electronically or by mail.
    b. Remote Telehealth – Support Coordinators conducting eligibility activities may accept evaluations from psychologists that were completed remotely. Telehealth evaluations with adaptive (or other, as applicable) assessments completed with telehealth technology (i.e. phone or secured video technology) should follow HIPAA requirements. In the event an in-person or telehealth evaluation or assessment is required by another policy or standard and cannot be completed, apply Presumed Eligibility protocols.
    c. Presumed Eligibility – In the event that an administrative evaluation is not possible, and substantiating documentation of all eligibility criteria (as per ADMH-DDD OG 8.2) is not available, any of the following substantiated data will be accepted:
        i. Most recent IQ test with Full Scale Intelligence Quotients (IQ) scores less than 70, prior to age 18.
        ii. A qualifying Intellectual Disability (ID) diagnosis by a Qualified Professional without an adaptive assessment, prior to age 18.
        iii. When testing or documentation of a qualifying intellectual disability is unavailable, an attempt to obtain the attached Physician's Statement should be made to verify:
            - ❖ The Qualified Professional can affirm an ID diagnosis;
            - ❖ The ID diagnosis directly causes an adaptive behavior impairment that significantly impacts Conceptual, Practical, Social functioning, or Socialization, Daily Living Skills, Communication areas; and
            - ❖ The qualifying condition and impairment are reasonably expected to have occurred prior to the age of 18.
    d. Presumed Eligibility Practices
        i. Notes in the web-based application must clearly identify why Presumed Eligibility policy is used for an applicant.
        ii. All notices of eligibility under Temporary Presumed Eligibility standards must indicate "Presumed Eligible" in the communication.

iii. The RCS Waiting List Coordinator must distinctly track Presumed Eligible cases and re-determine eligibility via standard means (as per ADMH-DDD OG 8.2) within one (1) year of the Presumed Eligibility determination.
iv. A new decision notice must be sent to all individuals determined Presumed Eligible within ten (10) business days of that determination.
v. Re-determination must be completed prior to twelve (12) months from the initial Presumed Eligibility determination.

3. Whenever possible, ADMH-DDD OG 8.2 should be followed if current documentation is available or telehealth technology will provide required eligibility documentation for the rule.
4. Eligibility determinations should be processed timely and not delayed unnecessarily. If the ADMH-DDD OG 8.2 requirements are not met by current available records, the Waiting List Coordinator should implement Presumed Eligibility within 30 days of identifying a possible Presumed Eligibility case.

8.3.c. Assistive Technology & Virtual Service Guidance via Appendix K/PHE2020

Responsible Office: Waiver Service Guidance
Reference: DDD HCBS Waivers
Effective: July 22, 2020
Revised: March 5, 2021
Statement: Assistive Technology and Virtual Services waivers per the COVID-19 Appendix K
Purpose/Intent: To provide guidance for accessing Assistive Technology and delivering virtual Services during the PHE/Appendix K waiver
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central Regional Offices; Self-directed Services
Procedure:
Assistive Technology

1. Through the effective period of the Appendix K, verbal orders are allowed in lieu of prescriptions for Assistive Technology.
2. The recommendation for Assistive Technology must be documented in the PCP and must include the following:
    a. Who made the recommendation
    b. Why the recommendation was requested/needed
        i. If a Service Coordinator identifies that assistive technology is needed to enable an individual to communicate with those outside their home or residence, they should complete the following steps:
        ii. Discuss with the individual and their team, as appropriate, if the addition of assistive technology would meet this need
        iii. If the individual agrees that the addition of assistive technology would meet this need, then,
        iv. the Support Coordinator (SC) must work with the individual to identify and document the most cost-effective means of meeting this need in the Person-Centered Plan or Progress notes.
            1. Examples include:

- A webcam for individuals who already have adequate access to a computer or laptop that meets their needs.
- A tablet or laptop with built-in camera for those without adequate access to appropriate technology that meets their needs.

v. SC then adds the service to the POC/PCP documenting why the assistive technology is the most cost-effective option selected
    1. The SC must ensure there is a plan for the person to access connectivity (explore internet providers that may be offering free WiFi or cellular internet access)
    2. The SC should assist in the development of an agreement for use of WiFi or internet if connectivity will occur utilizing the provider or family's system.
    3. The SC must identify if there are risks associated with using assistive technology and if so, address the risks with the PCP Team by updating the Risk Management Plan.
    4. The SC must determine whether individuals need support to set up or use the technology and create a plan for this support in the PCP.
    5. The SC must verify the agreed upon device was purchased and monitor the individual's progress towards the outcomes identified in the PCP.

Virtual Services

The Appendix K allows for an electronic method of service delivery (e.g., telephonic, virtual (like zoom), etc.). Services include Case management, Personal care that only requires verbal cueing, Day services, and monthly monitoring. Behavior Support Professionals, Nurses, and Occupational, Physical and Speech/Language Therapists may also provide electronic services in the home. Services should be documented in the person-centered plan and include why there is a need for electronic services (COVID-19) as opposed to the direct service that is traditionally provided.

NOTE: Virtual Services are intended to be used only in situations where in-person services are not advisable due to potential risk of exposure to COVID-19 and, therefore, should not be the first option for services.

8.4. Housing Specialist Access Request

Responsible Office: Regional Community Services
Statement: A Housing Specialist is assigned to each Regional Community Services Office.
Purpose/Intent: The Housing Specialist assists persons served on the Waiver with obtaining safe and adequate housing by guiding them through, and facilitating resolution of, the bureaucratic and financial processes involved. Scope: Housing Specialist; Director of Community Programs; Regional Community Services; Support Coordinator Definitions: RFA (Request for Action); IDT (Interdisciplinary Team); PCP (Person-Centered-Planning)
Procedures:

1. Notification is received via the Regional Office monitoring process, direct Support Coordinator referral, or the RFA process, that an individual is interested in obtaining housing.
2. The Housing Specialist attends the IDT meeting and/or PCP meeting in order to identify the individual's
   strengths and any barriers to housing stability and develops strategies to overcome these barriers.
3. The Housing Specialist takes the lead in coordinating the process of application, referral, contact with the Benefits Specialist and current Provider, while collaborating with the Support Coordinator.
4. Once housing placement is achieved, the Housing Specialist continues to provide mediation and advocacy along with educating the individual on tenant rights and responsibilities to promote successful community living.
    a. The duration and content of this ongoing support will be based on identified needs of the person and included specifically in their Person-Centered Plan.

8.5. Memorandum of Agreements (MOA) for non-contracted HCBS Waiver Services

Responsible Office: Waiver Service Guidance
Reference: DDD HCBS Waivers
Effective: November 1, 2020
Revised: March 5, 2021
Statement: Access to HCBS waiver services outside contracted provider network
Purpose/Intent: To establish a process to ensure access to HCBS waiver services when providers of those services are outside the contracted provider network and also, to ensure individual choice of vendors. (Examples may include the following: Environmental Accessibly Modifications, Personal Emergency Response System, Occupational, Speech and Physical Therapies). The MOA, if approved by the Associate Commissioner, can also be used for other services temporarily or until a contract can be fully executed depending on the type of service and identified need.
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions:
Procedures:

1. The Support Coordinator determines through Person Centered Planning or other means (physician's recommendation, interdisciplinary team meeting, etc.) whether the service may be needed and/or beneficial to the waiver participant.
2. The Support Coordinator ensures the request goes through the RFA process for approval and ensures supporting information is included in the request.
3. If the service is determined needed/beneficial and is approved by the Regional Office after review of supporting documentation, the Support Coordinator and Regional Office will work together to identify a provider of identified service.
4. The Regional Office CSD will ensure the provider meets waiver provider qualifications and can provide services as described in the Scope of Service (or waiver service description) then submits a request that includes vendor information to the Central Office for approval to execute an MOA.
5. If approved, the Central Office ensures the provider is registered in STAARS then develops the MOA and the vendor is added to a provider list.
6. Once the vendor is chosen, the vendor submits an invoice to the DD CO Fiscal Office for processing payment.
7. The DD CO Fiscal Office will process the Medicaid waiver claims billing and pay provider once Medicaid payment is received.
8. This provider list will be maintained and updated in the Regional Offices for future reference.
9. Expired MOAs must be renewed to remain on the Vendor List.
10. Regional Offices should ensure updated vendor lists are provided to Support Coordination agencies in their region.

Chapter 9
Waiver Service Descriptions

9.1. Waiver Services

9.1.a. ID and LAH Waiver Service Grid

Responsible Office: Office of Systems Management
Reference: ID and LAH Waivers
Effective: December 20, 2020
Statement: ID and LAH Waiver Service information is published to the ADMH website as the ID and LAH Waiver Service Grid.
Purpose/Intent: ID and LAH waiver service information, to include service name, service code, service rate, service limitations, and service definition, is published to the ADMH website as centralized, concise information about ID and LAH waiver services.
Scope: DDD HCBS Waiver Service Providers; Children's Waiver Services; ADMH-DDD Central/Regional Offices
Procedures:

1. The DDD Director of Systems Management:
    a. Updates the ID and LAH Waiver Service Grid as service rates change.
    b. Updates the ID and LAH Waiver Service Grid as services are added to the waiver.
    c. Updates the ID and LAH Waiver Service Grid as services are terminated from the waiver.
    d. Updates the ID and LAH Waiver Service Grid as waiver language relative to service definitions changes.
    e. Updates the ID and LAH Waiver Service Grid as waiver language relative to service limitations changes.
    f. Ensures the updated ID and LAH Waiver Service Grid is published to the ADMH website.
2. The ID and LAH Waiver Service Grid is published to the Division of Developmental Disabilities section of the ADMH
website as ID and LAH Waiver Service Grid.
3. Information in the ID and LAH Waiver Service Grid provides a brief overview, rather than a complete recreation of waiver language. Complete waiver documents are also provided on the ADMH website for a more thorough review of waiver service details.

9.2 Supported Employment

9.2.a. Discovery Assessment/Profile

Responsible Office: Office of Employment Services
Reference: ID and LAH Waivers; ADMH Administrative Code 580-5-30; Medicaid Administrative Code
Statement: Employment should be a first option for people receiving waiver services.
Purpose/Intent: DD Waiver services should be utilized to assist individuals with obtaining and maintaining employment
Scope: Support Coordinators, Providers, Families
Definitions: Discovery: A period of exploration to explore skills, interest, talents and abilities.
Procedures: A community-based assessment to develop a profile to pursue competitive employment. Discovery/Assessment is limited to no more than ninety (90) days and should not overlap other services and is available for individual participants interested in employment. The expectation is that much of the process be performed outside of a facility and off the grounds of the facility. The Discovery process should be individualized.

Discovery shall be limited to no more than 120 units (30 hours) of service. The provider shall document each date of service, the activities performed that day, and the duration of each activity completed. Reimbursement for discovery/assessment should be billed at three distinct intervals during the process.

The first billing for services occurs after one third, no more than 10 hours or 40 units, of the discovery/assessment process and requires documentation of activities performed that support the billing during the first period of the assessment process.

The second billing for services occurs at the two thirds, no more than 10 hours or 40 units, of discovery/assessment process and requires documentation of activities performed that support the billing during the second period of the assessment process.

The information developed through Discovery allows for activities of typical life to be translated into possibilities for integrated employment. Discovery results in the production of a detailed written Profile summarizing the process, learning and recommendations for next steps. The written Profile is due no later than ninety (90) days after the service commences.

The final payment for discovery/assessment is billed after the completion of the report and can include no more than 10 hours or 40 units of service. This service is limited to two assessments per each waiver participant, with the second assessment being conducted only if the participant changes service providers. To exceed the capped amount, documented justification should be sent to the Employment Coordinator at the Central Office, or the Employment Specialist at the Regional office.

Approvals will then follow the established request for service procedures. No waiver participant can receive more than four discovery/assessment services over the lifetime of the waiver.

Participation in Pre-Vocational services is not a requirement for Discovery. If the same agency that completes the Discovery is also the agency that provides other employment services, i.e. job development, job coaching, etc., VR should not be billed for an additional Discovery service.

9.2.b. Pre-Vocational Services- Pathway to Employment

Approved by Associate Commissioner:
Responsible Office: Office of Employment Services
Reference: ID and LAH Waivers; ADMH Administrative Code 580-5-30; Medicaid Administrative Code
Statement: Individuals receiving prevocational services must have employment-related goals in their Person- Centered Plan
Purpose/Intent: Prevocational services are utilized to prepare an individual for paid employment and are not job-task oriented, but instead aimed at a generalized result.
Scope: Support Coordinators, Providers, Individuals, Families
Definitions: A generalized service that helps an individual progress down a defined pathway to employment. Only individuals interested in integrated and competitive employment should receive this service.
Procedures: The Prevocational habilitation service under the Waiver is designed to create a path to integrated, competitive employment in which an individual is compensated at or above the minimum wage, but no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Pre-vocational services include teaching such concepts as attendance, task completion, problem solving, interpersonal relations and safety, as outlined in the individual's person-centered plan. Prevocational services provide learning and work experiences, including volunteer work, where the individual can develop general, non- job-task specific strengths and skills that contribute to employability in paid employment in integrated community settings. Pre-vocational services should occur as much as possible outside the facility and off the grounds of the agency. A best practice would include a minimum of 50% of the service occurring in the community.

Services are expected to occur within a period **not to exceed 2470 units**, with employment (integrated and competitive salary/wage) being the specific outcome. A pre-vocational unit is defined as one hour.

During participation in pre-vocational services, the expectation is that a referral will be made to the Alabama Department of Rehabilitation Services/VR when the individual is ready to move forward with obtaining a competitive job.

If, after the 2470 hours of service, a person has not been referred to ADRS, obtained competitive employment or moved into other waiver services, the provider **must** justify why additional Prevocational habilitation services would be beneficial to continue the individual on a "pathway to employment". The request for continuing this service must be made in writing, along with supporting documentation to the Office of Supported Employment in the Central Office or to the designated Employment Specialist working in the Regional Office. The Employment Coordinator and/or Employment Specialists will review the request and notify the Support Coordinator of the decision to

approve or deny the request. If approved, the Support Coordinator will begin the RFA process to the Regional Office.

Individuals receiving prevocational services must have employment-related goals in their Person-Centered Plan; the general habilitation activities must be designed to support such employment goals. **If the beneficiaries are compensated, they are compensated at less than 50 percent of the minimum wage;** 42CFR 440.180 (c) (2) (i)

Participation in prevocational habilitation services **is not** a required pre-requisite for individual or small group supported employment services under the waiver.

9.2.c. Vocational Rehabilitation

Responsible Office: Office of Employment Services
Reference: ID and LAH Waivers; Medicaid Administrative Code
Statement: Individuals that express interest in competitive integrated employment should be referred to the Alabama Department of Rehabilitation Services (ADRS), Vocational Rehabilitation (VR).
Purpose/Intent: VR is funded by the Rehabilitation Act of 1973 or P.L. 94-142. These services should be accessed prior to waiver funding for supported employment services.
Scope: Support Coordinators, Providers, Individuals, Families
Definitions: Supported employment (SE) services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that: A generalized service that helps an individual progress down a defined pathway to employment. Only individuals interested in integrated and competitive integrated employment should be referred to VR.
Procedures: Vocational Rehabilitation Service (VRS), the largest division within the Alabama Department of Rehabilitation Services that assists Alabamians with disabilities achieve independence through employment.

VR provides specialized employment- and education-related services and training to assist teens and adults with disabilities in becoming employed.
The types of services available through VR are varied and designed specifically to meet the needs of each individual. Available through any of the 20 VRS offices statewide, services can include pre-employment services, transition services, educational services; vocational assessments and evaluations, guidance and counseling; job training; assistive technology; orientation and mobility training; and job placement and retention.

To be eligible for services, individuals must have a physical or mental impairment which results in a substantial barrier to employment, and there must be a reasonable expectation that he or she can benefit from rehabilitation services in terms of becoming employed.

To determine the appropriate VR office in your area, please visit www.rehab.alabama.gov and click on office locations.

When an individual receiving ADMH funded waiver supports expresses interest in competitive employment, the plan to support this goal should include a referral to VR. There are several steps that should be taken to ensure the appropriate referral process is followed, along with making sure the individual is interested in competitive integrated employment.

1. Once an individual expresses interest in working in competitive employment, an initial "Discovery" assessment should be provided. The Discovery process is an evidence-based alternative to comparative, standardized assessments, and evaluations completed by a qualified employment supervisor professional. Discovery is a person-centered planning process that involves getting to know a person before supporting them in developing a plan for employment. (See Operational Guideline 9.2.a. for more information on Discovery)
2. Once the Discovery assessment is complete and the individual continues to express interest in working, additional steps should be taken to assist the individual. These steps include:
    a. A meeting held with the individual to complete benefits planning. The benefits planning can be provided by either the ADMH funded Community Work Incentives Coordinator or a provider agency with an "approved and certified" benefits planner. (See operational Guideline 9.5. for more information on Benefits Planning).
    b. A meeting either in person or via conference call should be held with the individual and team which may include provider agencies, the support coordinator, family members, etc. During this meeting, the plan for work is finalized so an appropriate referral to VR is made.
        - Transportation options should be discussed so that once the employment goal is achieved, the individual encounters no difficulty getting to and from work.
        - A determination is made regarding the individual/agency responsible for assisting with ongoing benefits reporting. (See operational guideline 9.5. for more information on benefits reporting).
        - Contact should be made with the local VR office and an appointment scheduled so individual can officially apply for VR services.
        - A release form should be signed by the individual to grant permission for referring agencies (day and/or residential, support coordinator, etc.) to provide records to VR to determine eligibility. This release form should also grant permission for VR to discuss eligibility, need for additional information, etc. with the service coordinator or whoever the individual chooses. With provision of appropriate records, eligibility should be determined within 60 days. See Alabama Department of Mental Health Alabama Department of Rehabilitation Services Authorization/Consent for Use or Disclosure
    c. Once an individual is determined eligible for VR services, the ADRS Counselor will refer the individual to an authorized supported employment service provider (funded by ADRS utilizing a Milestones payment system). The service provider will complete the following milestones:
        - Determination of Need: 2 Situational Assessments, PCP (vocational) Plan, or the Discovery Profile. (Milestone I/Discovery/PCP) should not be needed if agency has completed the Discovery utilizing Waiver funding).

- Hire: The individual is placed into competitive employment and completes 3 days on the job.
- Job Retention: The individual receives onsite job coaching to ensure that satisfactory job performance is achieved to maintain employment.
- Closure: After initial job coaching (retention services) is provided to achieve stabilization, VR will provide an additional 90 days of post stabilization follow up. Once the 90 days are complete, the VR case is closed as successfully rehabilitated (employed).

d. Waiver services should be utilized throughout this process to support the individual working in competitive employment. Services that could be utilized to support long-term needs include:
   - Ongoing benefits planning and/or reporting services
   - Personal Care and/or Personal Care at the Worksite
   - Employment Transportation
   - Job Coaching

3. If VR determines that an individual isn't eligible for services for any reason, waiver support can be utilized to provide the job developer service. (Please see Operational Guideline 9.2.d.1. for more information on job developer).
   a. If the VR counselor, after trial work experiences determines that the consumer cannot benefit from SE services, or that SE services are not available in their area, VR should provide a letter explaining the findings and this should be provided to ADMH provider. This documentation allows an ADMH agency to provide supported employment under the waiver.
   b. If VR fails to provide a written statement regarding ineligibility, the support coordinator, provider agency, etc. should document the efforts that were made to access VR services. This documentation should include the dates the individual met with the VR Counselor, the name of the VR Counselor, any verbal feedback that was provided by VR to the individual or referring agency or support coordinator, etc. This documentation should be included in the individuals file that confirms that reasonable attempts were made to access VR prior to utilizing any waiver funds. If individual refuses to pursue VR services (choice) this should also be clearly documented in the file. Reasons for refusal should be detailed.

9.2.d. Individual Supported Employment Services

9.2.d.1. Job Developer

Responsible Office: Office of Employment Services
Reference: ID and LAH Waivers; ADMH Administrative Code 580-5-30; Medicaid Administrative Code
Statement: A distinct service that supports Individualized Supported Employment – Job Developer. Purpose/Intent: Job developer services are available to support an individual in obtaining integrated, competitive employment.
Scope: Support Coordinators, Providers, Individuals, Families
Definitions: A distinct service that is utilized to help an individual obtain a job. This supported employment service is not available to recipients eligible for benefits under a program funded by either Section 110 of the Rehabilitation Act of 1973, or P.L. 94-142.

Procedures: When an individual expresses interest in obtaining a job, a referral should be made to the Alabama Department of Rehabilitation Services (VR). Once the referral is made to VR, the individual, along with the Support Coordinator and/or service provider should maintain contact with the VR Counselor to ensure follow through with eligibility determination. This VR eligibility determination should be made as soon as possible, but no later than 60 days from the initial application date. The individual is encouraged to provide a signed release to VR, so the VR Counselor can speak with the Service Coordinator and/or provider agency representative if necessary for additional information and/or monitor progress towards eligibility determination. Historically, VR has been hesitant to speak with anyone other than the individual due to HIPAA regulations.

If deemed eligible by VR, the individual is expected to receive the job development service which is necessary for competitive and integrated employment. However, if VR determines that individual does not meet eligibility criteria or services through VR are otherwise not available, the Job Developer service is available through the Waiver.

The Individualized Job Developer primarily markets the supported employment service and the person's skills with potential employer(s). This might include employer negotiation related to waiver recipient's skills, negotiating hours or location to meet needs of the waiver recipient, job carving, job placement, etc. Often the job developer will be out in the community performing the activities with or without the waiver recipient.

This Job Developer service will be limited to 40 hours per year. An employment plan is required initially, and subsequent updates can request modifications to the above limitations based on the observations of the professionals involved and approved by the RO Employment Specialist/Coordinator.
Training Requirements: A job developer must complete an ADMH approved training curriculum. Examples of approved curriculums include the bi-annual Customized/Supported Employment training taught by consultants from Virginia Commonwealth University, or an approved web-based certification available through such entities as ACRE, Griffin Hammis, etc. Please contact the Office of Supported Employment with any questions related to approved certifications.

9.2.d.2. Job Coach

Responsible Office: Office of Employment Services
Reference: ID and LAH Waivers; ADMH Administrative Code 580-5-30; Medicaid Administrative Code
Statement: A distinct service to support individuals at worksite – Job Coach
Purpose/Intent: The job coach service is provided to teach skills and provide support at a worksite to enable individuals to achieve the highest level of independence possible.
Scope: Support Coordinators, Providers, Individuals, Families
Definitions: A service that is utilized to teach job skills for competitive integrated employment and provide long term supports and follow up for job retention. This service if, furnished under the waiver, is not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.
Procedures: The job coach works directly with an individual that desires to work in competitive integrated employment. The minimal requirement for an individual providing the job coach service is graduation from high school or its equivalent and two years of work experience. A Bachelor's Degree with a major concentration in rehabilitation, industrial arts, vocational education, psychology or a

related field is preferred. Work experience of a supervisory or training nature as well as knowledge of persons with disabilities would be particularly desirable.

The job coach service covers a variety of assistance that supports an individual in obtaining and maintaining employment. The hours worked by the job coach must be flexible to meet needs as they arise. The amount of job coach support will depend on the needs of the individual being supported, which will also influence the number of job coaching hours that should be authorized. It is expected that the job coach will fade his or her support as the individual becomes more integrated into the employer's workforce and grasps work tasks. It is also acceptable to supplant some of the job coach's faded hours thorough the utilization of personal care at the worksite. The overall goal of job coaching is to develop independence at the worksite

Overall, the Job Coach is responsible to the Program Director for the training and associated support services necessary to ensure the success for individuals involved in Supported Employment. These services might include:

1. Completion of job analysis's and/or task analysis's through employer interviews, actual job performance to ensure a thorough understanding of the specific job and general job rules prior to placement of the individual;
2. Teaching work skills/tasks, responsibilities and behaviors not related to the specific job being performed, such as how to complete a timecard, when and where to take bathroom and lunch breaks;
3. Ensuring that each individual placed into employment receives the necessary support to become an integrated member of the work force. This may happen in the general course of the job but could require activity such as encouragement of the individual worker or other employees to communicate with each other, or the provision of disability awareness training to workers of the company;
4. Working with the individual to be placed in employment and/or with family or service provider to ensure that the individual has reliable transportation to and from work, adequate housing, and emotional support for his or her job efforts;
5. Making every effort to ensure that the individual in supported employment is matched to an appropriate job using a comprehensive vocational assessment (Situational Assessment and/or Discovery) prior to job placement. Part of the assessment may include reviewing current progress notes in individual's present placement, studying referral information, and working with the individual to assess work skills;
6. Communicating through written and oral reports on the progress of individual's in supported employment to the Program Director and other program staff: follow oral or written instructions (such as the care plan or rehabilitation plan);
7. Providing continued ongoing support to individuals in supported employment;
8. Performing other job duties necessary to ensure the success of individuals in supported employment as well as any additional tasks assigned by the Program Director that will be of benefit to other individuals in the program.
9. Facilitating job accommodations and use of assistive technology;
10. Educating the person and others on the job site regarding rights and responsibilities and the role of self-advocacy in the workplace.

Individuals providing job coaching services should complete the ADMH recognized training on customized/supported employment. Currently, the 3-day certificate-based training taught by consultants from Virginia Commonwealth University is recommended. Other curriculums must be approved by the ADMH Office of Employment Services.

9.3. Supported Employment Small Group

Responsible Office: Office of Employment Services
Reference: ID and LAH Waivers; ADMH Administrative Code 580-5-30; Medicaid Administrative Code
Statement: Services and training activities provided in a regular business or industry in community settings for groups of two (2) to four (4) workers.
Purpose/Intent: This intent of this service is sustained paid employment and work experience leading to further career development and community-based individualized employment.
Scope: Support Coordinators, Providers, Individuals, Families, Regional Community Service Offices
Definitions: Service that teaches job skills to a workgroup such as mobile work crews and other business-based workgroups employing small group of workers. The goal of this service is to develop skills that lead to individualized competitive employment in the community. This service is not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.
Procedures: Supported Employment Small Group must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience that leads to further career development and community-based employment for which the compensation is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

The supported employment small group works in community-based integrated settings in groups from 1:2-3 or 1:4 workers. This service should not occur in facility-based settings or other similar types of vocational settings that are not part of the general workplace. These workgroups should only perform work in integrated community-based settings with competitive wages.

Supported Employment Small Group providers must meet the same standards as Day Habilitation providers. The staffing pattern should be appropriate to the type and scope of program services and should include staff members who meet the experience and educational qualifications set forth in the job coaching service. No individual in this service should ever be left unsupervised unless the activity is part of a structured activity outlined
in the person-centered plan.

9.4. Transportation

Responsible Office: Office of Employment Services
Reference: ID and LAH Waivers; ADMH Administrative Code; Medicaid Administrative Code
Statement: Service that provides waiver participants access to and from their place of employment in the event the support team is unable to facilitate transportation through other means.
Purpose/Intent: The intent of this service is to ensure an individual has transportation to and from their place of employment. This service should only be accessed when other means of transportation cannot be identified or facilitated.
Scope: Support Coordinators, Providers, Individuals, Families, Regional Community Service Offices
Definitions: Employment transportation is the provision of service to permit waiver participants access to and from their place of employment in the event the support team is unable to arrange alternate means of transportation to and from work. The provision of this service must be necessary to support the person in work related travel and cannot be reimbursed for merely transportation. This service is not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.
Procedures: Employment transportation is a distinct service to transport an individual to and from an integrated competitive employment setting. The team's efforts to secure transportation must be documented in the case record. This service shall not duplicate or replace the Medicaid non-emergency medical transportation program. This does not preclude other arrangements such as transportation by family or friends. It is the expectation that as part of the person-centered planning process and employment outcomes, long term transportation to and from the worksite will be facilitated and arranged.

Payment for this service will be reimbursed based on the IRS mileage rate and required documentation (i.e. vendor receipt or travel log) of service by the mile. This unit of service is a mile. Documentation should also include progress toward obtaining long term transportation as part of measuring the employment outcomes.

Transportation must be provided by public carriers (i.e. charter bus or metro transit bus) or private carriers (i.e. taxicab). Commercial transportation, including day or residential provider agencies – must have a business license. All drivers must have a valid driver's license of appropriate type (i.e. commercial) for transport in Alabama. Also, all vehicles transporting individuals must have insurance as required by law. The agency employing any driver should ensure that the driver has a good driving record and receives in-service training on safety procedures when transporting an individual.

This service shall not replace transportation that is already reimbursable under day or residential habilitation. This service is reserved for only those waiver participants who are employed. The planning team must also assure the most cost-effective means of transportation, which would include public transport when available. Employment
transportation is not intended to replace generic transportation or to be used merely for convenience.

9.5. Benefits Planning and Reporting

Responsible Office: Office of Employment Services
Reference: ID and LAH Waivers; ADMH Administrative Code 580-5-30; Medicaid Administrative Code
Statement: Employment should be a first option for people receiving waiver services.
Purpose/Intent: Benefits Planning and Reporting Services should be utilized to help people manage benefits when pursuing and obtaining employment.
Scope: Support Coordinators, Providers, Families
Definitions: Benefits Planning and Reporting Services enable individuals to work while maintaining needed Social Security and medical benefits.
Procedures:
An individual wishing to pursue employment should be referred for benefits planning and reporting services. This can be provided either by an ADMH funded CWIC (Community Work Incentive Coordinator) or by the provider agency.

1. The Alabama Department of Mental Health provides Social Security Benefits Planning and Reporting services in all 5 DD regions. This service is provided by 4 Community Work Incentive Coordinators (CWICs). Self-referrals or partner referrals can be made on a beneficiary's behalf. To request CWIC services, please email: maryjane.dasher@mh.alabama.gov or contact **256-366-7612**. (Necessary records will be obtained, including releases and forwarded on to the appropriate CWIC).

2. Provider agencies may offer these services directly and receive waiver reimbursement if:
    a. For benefits planning, the agency must employ a credentialed staff member. This credentialing requires completion of either a national recognized Community Work Incentive Coordinator training or web-based Work Incentives Planning and Utilization for Benefit Practitioners Certificate Series offered through Cornell University. The benefits planning is capped at 60 Units per individual. (15-minute units)
    b. For benefits reporting, the agency must employ a staff member that meets requirements outlined in (a)- above or have a staff member that has participated in a Social Security Work Incentives overview, provided by an ADMH - CWIC. An ADMH Employment Specialist can arrange this training session or provider can reach out directly to: Maryjane.dasher@mh.alabama.gov or **256-366-7612**. A certificate of completion is necessary and should be provided to Support Coordination agency and others approving RFAs. The benefits reporting is capped at 144 Units per individual. (15-minute units).
3. ***Please Note: Benefits reporting should only be provided and billed on individuals earning more than $85.00 per month. SSI recipients automatically qualify for an $85.00 Earned Income Exclusion, so wage reporting wouldn't be necessary. For more information about work incentives visit at www.ssa.gov/disabilityresearch/workincentives.htm and www.ssa.gov/redbook**.
4. The agency requesting a benefit reporting service should provide copies of individual's check stubs to be added to the RFA to confirm both employment and wages.
5. Documentation of provided service(s) should be maintained in individual's file.

6. Reporting should be provided to individuals to avoid any overpayment or jeopardize loss of benefits and medical coverage.

CHAPTER 10
Self-Directed Services

10.1. Self-Directed Services Handbook

Responsible Office: Self-Directed Services
Reference: ID/LAH HCBS Waivers
Effective: November 1, 2020
Statement: The term "self-direction" refers to a service delivery option in which the individual who receives waiver services decides how, when, and from whom those services will be delivered. Self-direction is designed to make service delivery as flexible as possible for individuals and their families, and to make sure individuals who self-direct can exercise maximum choice and control over their services and supports.
Purpose/Intent: The Self-Directed Services Handbook is designed to provide information to participants, representatives, family members, support coordinators, and Self-Directed Liaisons about self-directed services available through the Alabama Intellectual Disabilities and Living at Home Waiver for Persons with Intellectual Disabilities (ID/LAH Waiver).

Self-direction comes with many benefits, and it also comes with responsibilities. This handbook is designed to be a detailed resource about the self-directed services offered through Alabama's Intellectual Disabilities and Living at Home Waiver.

This handbook can help people who are new to the Intellectual Disabilities and Living at Home Waiver or to self-directed services learn more about how the self-directed model works—and how to make self-direction work best for them!
Procedures: Refer to Self-Directed Services Handbook

10.2. Referral to Self-Directed Services

Responsible Office: Self-Directed Services
Reference: ADMH/DDD Operational Procedures
Effective: November 1, 2020
Purpose/Intent: Provide the process to refer individuals to be considered for self-directed services option.
Scope: Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions: SDS (Self-Directed Services) –A service delivery option; SDL (Self-Directed Liaison) –An individual who provided SDS application packet explanation of the procedures; RFA (Request for Action) – Additions to an individual's plan of care; ADIDIS (Alabama Developmental Intellectual Deficits Information System); FMSA (Financial Management System Agency) – Agency that provides payroll services to individuals who select SDS; EOR (Employer of Record) –Individual who will be responsible for oversight of SDS with in the home; EIN (Employer Identification Number)
Procedures: All requests to enroll an individual into the Self-Directed Services option must be completed and submitted by the Support Coordinator to the Regional Office via the Request for Action (RFA) process. The Support Coordinator should attach self-directed services referral form with the RFA forms when submitting to the appropriate regional office.

PROCEDURES FOR SUPPORT COORDINATOR

1. Hold a meeting with the individual and/or his/her family to explain the service delivery option of self-directed services.
2. Provide the individual and/or family member with a copy of the SDS Handbook and answer questions detailing the difference between the self-directed service option and traditional service delivery option.
3. If individual and/or family indicate an interest in the self-directed services option, then the Support Coordinator must complete the entire SDS Referral form and RFA form.
4. Submit the completed SDS Referral form (Revised 6/2/2020) and RFA form to the appropriate regional office via the RFA process outlined in Operational Guideline 4.2. When the RFA is submitted in ADIDIS the Support Coordinator should tag the CSD, waiver coordinator and SDL.

PROCEDURES FOR SELF-DIRECTED LIAISON

1. After the RFA Committee in the Regional Office renders a decision, then the Self-Directed Liaison will contact the individual.
2. If the RFA for SDS Referral is approved, then the SDL will contact the individual/family member to provide self-directed services application packet and schedule a meeting to discuss the SDS information.
3. This SDS approval is for enrollment into the SDS delivery option. The individual cannot begin to employ individuals until he/she has received a hire date from the FMSA. Services performed prior to the hire date will not be reimbursed by waiver funds.
4. Submit information to the Financial Management System Agency for review.

PROCEDURES FOR FINANCIAL MANAGEMENT SERVICES AGENCY

1. Receive documents submitted
2. Process documents and determine if individual/family can obtain an employer identification number (EIN) and become an employer of record (EOR).

3. Process employee application and background checks for potential employees.
4. If there are problems with the application or it is incomplete, this will delay the process. The FMSA will send an email to the SDL or EOR to request additional information.
5. Once the EOR has been approved, then they receive notification of their EIN number.
6. Once the employee is approved to work, then the FFMSA will send an email with the employee hire date.

10.3. Purchase of Goods, EAA, SME, SMS, PERS

Responsible Office: Self-Directed Services
Reference: ADMH/DDD Operational Procedures; ID/LAH HCBS Waivers
Effective: November 1, 2020
Purpose/Intent: Provide the process to obtain and be reimbursed for specialized medical equipment, specialized medical supplies, environmental accessibility adaptations, personal emergency response system and other goods.
Scope: Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions: Specialized Medical Equipment (SME), Specialized Medical Supplies (SMS), Environmental Accessibility Adaptations (EAA), Personal Emergency Response System (PERS)
Procedures:
Procedures for Employer of Record:

1. Prior to making a purchase the individual/employer of record (EOR) should submit the request to use waiver funds for purchases to his/her Support Coordinator
2. The EOR should review his/her budgetary savings report to determine if the funds are available for the purchase of goods
3. The request should provide explicit details about the reason for the purchase and how it will benefit the waiver recipient.
4. The request should include three quotes for the items being purchased with the exception of specialized medical supplies.

Procedures for Support Coordinator:

1. The Support Coordinator should review the person-centered plan and plan of care to ensure that the requested good or service is identified.
2. The Support Coordinator should review the monthly utilization report (budgetary savings report) to ascertain if the individual has the funds available for purchase.
3. The RFA should include a detailed explanation of reason for purchase, most recent copy of budgetary savings report, three quotes for the item, completed prior approval form (revised 10/19/2020) and ensure the purchase aligns with waiver stipulations and person-centered plan for the service or goods.
4. The Support Coordinator must submit the request to the regional office via the Request for action (RFA) process (see OG 4.2) in ADIDIS and tag the CSD, waiver coordinator and self-directed liaison.

Procedures for Regional Office:

1. Verify all information is included on the RFA. If not, return to support coordinator with a note in the NEEDED INFORMATION section of the form. Include the date returned to the support coordinator.
2. Verify the documentation supports the need for service and person-centered plan
3. Approved; generate letter to the participant with a copy to the Support coordinator
4. Denied; generate letter to the participant accompanied by appeal rights with a copy to the Support coordinator
5. Inform the self-directed liaison of the decision

Procedures of Support Coordinator after Regional Office Review:

1. Inform the waiver recipient/employer of record of the Regional Office decision or request for additional information
2. If additional information is required by Regional Office, then request the additional information be provided by the EOR.
3. Submit additional information to the regional office.

Procedures for waiver recipient/employer of record to purchase items after receiving approval:

The EOR has two options to obtain items

1. Pay the provider directly for items and submit receipts to their Support Coordinator for reimbursement –OR--
2. Have the supply vendor send a W-9 form to financial management service agency (FMSA) so that FMSA can pay the supply vendor directly. In this scenario, receipts should also be sent to the support coordinator to keep with the person's records.

Procedure for Support Coordinator after EOR submits receipts:

1. Email or fax the previously approved Prior Approval form and receipts to financial management service agency.
2. Retain a copy of the Prior Approval form and receipts with the person's records

APPENDIX

Exhibit 1.2.a

Criteria for Determining Eligibility and placement on the Waiting List

Exhibit 2.2.

Dissatisfaction of Services

Exhibit 4.5.

Monitoring - Individual Experience Assessment Survey

Exhibit 5.1.

New Provider Enrollment

Exhibit 6.1.

Certification Review Process

Exhibit 6.4.

Incident Prevention and Management System (IPMS)

Exhibit 10.1.

Self-Directed Services: A Handbook

KAY IVEY
GOVERNOR

STATE OF ALABAMA
DEPARTMENT OF MENTAL HEALTH
RSA UNION BUILDING
100 NORTH UNION STREET
POST OFFICE BOX 301410
MONTGOMERY, ALABAMA 36130-1410
WWW.MH.ALABAMA.GOV

KIMBERLY G. BOSWELL
COMMISSIONER

NOTICE OF APPEAL RIGHTS ADVERSE DECISION

Exhibit 2.1.a.

If an individual/guardian chooses to appeal an adverse decision, they may choose to appeal first to the Alabama Department of Mental Health (ADMH), and if not satisfied with the decision rendered in that appeal, may then further appeal to the Alabama Medicaid Agency (Medicaid). Or, they may appeal first directly to Medicaid. Please check the box below for your option of appeal:

☐ **REQUEST AN APPEAL TO THE ALABAMA DEPARTMENT OF MENTAL HEALTH**

To appeal first to the ADMH/Associate Commissioner for the Division of Developmental Disabilities. A written request for an appeal must be received by the Associate Commissioner for Intellectual Disabilities no later than 15 calendar days after the effective date printed on the Notice of Action. A written decision from the Associate Commissioner will be mailed (certified) to the individual/guardian within 21 days after the review of all information. If the individual/guardian disagrees with the Associate Commissioner's decision, he/she can request a Fair Hearing to the Medicaid. A written hearing request must be received by Medicaid no later than 15 calendar days from the date of the Associate Commissioner's letter. Send written requests for appeal/fair hearing to:

ADMH-Division of Developmental Disabilities
P.O. Box 301410
Montgomery, AL 36130-1410

☐ **REQUEST AN APPEAL/ FAIR HEARING TO THE ALABAMA MEDICAID AGENCY**

If the individual/guardian choses to first appeal to the Alabama Medicaid Agency, a written request asking for a fair hearing must be received by Medicaid within 60 days from the date the Notice of Action is mailed. The individual/ legally appointed representative or other authorized person must request the hearing and give a correct mailing address. If the request for a hearing is made by someone other than the person who wishes to appeal, the representative must make a definite statement that he has been authorized to do so by the persons for whom the hearing is being requested. Information about hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the persons will be arranged. If the person is satisfied before the hearing and wants to withdraw his request, he or his legally appointed representative or other authorized person should write the Alabama Medicaid Agency that he wishes to do so and give the reason for withdrawing.

The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy, which requires an automatic change adversely affecting some or all recipients. When benefits are terminated, they can be continued if a hearing request is received within ten (10) days after the effective date of Notice of Action, unless there are unnecessary delays by the person requesting the hearing for this representative. If benefits are continued pending the outcome of the hearing and the Hearing Officer decided that termination was proper, Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.

MEDICAID ELIGIBILITY DIVISION POLICIES AND PROCEDURES ARE IN COMPLIANCE WITH THE CIVIL RIGHTS ACT OF 1964 AND SECTION 504 OF THE REHABILITATION ACT OF 1973

Send written requests for reviews and fair hearings to:

ALABAMA MEDICAID AGENCY
Long Term Care Division
P.O. Box 5624, 501 Dexter Avenue
Montgomery, AL 36103-5624

I have reviewed and been given a copy of my right to a Medicaid review of the case and/or a Fair Hearing.

Signature of Recipient or Legal Representative _____ Date _____

Print Recipient's Name _____ Witness Signature and Date _____

KAY IVEY
GOVERNOR

STATE OF ALABAMA
DEPARTMENT OF MENTAL HEALTH
RSA UNION BUILDING
100 NORTH UNION STREET
POST OFFICE BOX 301410
MONTGOMERY, ALABAMA 36130-1410
WWW.MH.ALABAMA.GOV

KIMBERLY G. BODWELL
COMMISSIONER

DISSATISFACTION OF SERVICES Exhibit 2.2.

The Dissatisfaction of Services form is a disclosure required by Alabama Medicaid to ensure a person enrolling or already receiving HCBS waiver services and their legally authorized representative are aware that they have the right to due process should they become dissatisfied with Medicaid funded services. Please check the box below indicating your preferred method of review:

☐ **REQUEST CONFERENCE OR REVIEW OF CASE**

A person who is dissatisfied with his/her services under the Medicaid Home and Community-Based Waiver program (Living at Home Waiver or Waiver for Persons with Mental Retardation) may notify the Alabama Medicaid Agency giving the reason for the dissatisfaction and ask for either a conference or a review of the case by the Alabama Medicaid Agency. At the conference, the person may present the information or may

☐ **REQUEST A FAIR HEARING**

A written request for a hearing must be filed within sixty (60) days following the action with which the person is dissatisfied. He, his legally appointed representative or other authorized person must request the hearing and give a correct mailing address. If the request for a hearing is made by someone other than the person who wishes to appeal, the representative must make a definite statement that he has been authorized to do so by the persons for whom the hearing is being requested. Information about hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the persons will be arranged. If the person is satisfied before the hearing and wants to withdraw his request, he or his legally appointed representative or other authorized person should write the Alabama Medicaid Agency that he wishes to do so and give the reason for withdrawing.

The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy, which requires an automatic change adversely affecting some or all recipients. When benefits are terminated, they can be continued if a hearing request is received within ten (10) days following the effective date of termination, unless there are unnecessary delays by the person requesting the hearing for this representative. If benefits are continued pending the outcome of the hearing and the Hearing Officer decided that termination was proper, Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.

MEDICAID ELIGIBILITY DIVISION POLICIES AND PROCEDURES ARE IN COMPLIANCE WITH THE CIVIL RIGHTS ACT OF 1964 AND SECTION 504 OF THE REHABILITATION ACT OF 1973

Send written requests for reviews and fair hearings to:

ALABAMA MEDICAID AGENCY, Long Term Care Division, P.O. Box 5624, 501 Dexter Avenue Montgomery, AL 36103-5624

I have reviewed and been given a copy of my right to a Medicaid review of the case and/or a Fair Hearing.

Signature of Recipient or Legal Representative _____ Date _____

Print Recipient's Name _____ Witness Signature and Date _____

ADMH – Division of Developmental Disabilities	Individual Experience Assessment Survey (IEA)

Section A: General Information - A response to each question is required unless otherwise indicated.

1. Person's First and Last Name:	Date of Survey:
2. Does the person have a legal guardian? **If no, skip to question 4. If yes, answer 3a – 3b** A guardian is a person appointed by the probate court to oversee the personal and/or financial affairs of an adult who is determined to be incapable of managing his or her own affairs or unable to care for himself or herself.	☐ Yes ☐ No
3. If yes, is the guardian a paid/corporate guardian (i.e., the guardian is an attorney or works for an agency), or an unpaid family/friend?	☐ Paid Guardian ☐ Unpaid Guardian
a. If Unpaid Guardian, enter the name of the Guardian	
b. If Paid Guardian, Enter the name of the Guardian/ Agency	
4. In which Waiver is person enrolled (select one): ☐ ID Waiver ☐ LAH Waiver	
Name of Support Coordinator Conducting IEA:	
Support Coordinator employed by:	
5. Number of months SC has supported person:	6. Region (circle one): 1 2 3 4 5
7. Is someone other than the person responding to the survey (if the person is not able to answer one or more of the questions independently)? If **NO** skip to Section B If **YES,** answer 7a – 7b	☐ Yes ☐ No
7a. If yes, what is the First and Last name of the person assisting with responses?	
7b. What is his/her relationship to the person?	☐Child ☐Spouse/Partner ☐ (Other)Family ☐Friend ☐DSP ☐Guardian

Section B: HCBS Setting Experience Overall All participants are required to complete this section

Question:	Response:	HCBS Setting Requirement:
1. Do you have your own bank account?	☐ Yes ☐ No	*Allows person to control personal resources.*
2. Do you have access to your money?	☐ Yes ☐ No	
3. Can you buy the things you need?	☐ Yes ☐ No	
4. Did someone tell you about the services and supports available to you?	☐ Yes ☐ No	*Facilitates personal choice regarding services and supports and who provides them.*
5. Did you choose the services and supports you receive?	☐ Yes ☐ No	
6. Were you given options to choose from when selecting the agency that provides your services and supports?	☐ Yes ☐ No	
7. Did you choose the specific person/people who provide your services and supports?	☐ Yes ☐ No	
8. Do you know how to request a change in your services and supports?	☐ Yes ☐ No	
9. Do you know how to request a change in who provides your services and supports?	☐ Yes ☐ No	
Does this person participate in Employment or Day Services? If yes, complete Section C; If no, SKIP Section C		

Section C: Employment and Day Services

10. Select the funding for Employment/Day Service(s) the person is receiving	☐ ID Waiver ☐ LAH Waiver ☐ADRS

11. Name of Service Provider	Address	
Does the person have more than one Employment/Day services provider? If yes, enter the 2nd provider name; If no, skip to question 1		
12. Name of 2nd Service Provider	Address	
Question:	Response:	HCBS Setting Requirement:
1.Do you have a job?	☐ Yes ☐ No	*Provides opportunities to seek employment and work in a competitive environment.*
2.Could you have a job if you want one?	☐ Yes ☐ No	
3.Do you have the help you need to look for a job if you want one?	☐ Yes ☐ No	
4.Can you be alone if you want to?	☐ Yes ☐ No	*Ensures person's rights of privacy, dignity, respect and freedom from coercion and restraint.*
5.Can you have a private conversation without others listening?	☐ Yes ☐ No	
6.Is your personal information kept secure so others can't see it?	☐ Yes ☐ No	
7.Do the people who support you treat you the way you want to be treated?	☐ Yes ☐ No	
8.Do the people who support you listen to your questions or concerns?	☐ Yes ☐ No	
9.If you want to, can you go out in the community?	☐ Yes ☐ No	*Integrated, and supports, access to the broader community.*
Does the person participate in Residential Services? If YES, complete Section D; If NO, SKIP Section D		(circle YES or NO)
Section D: Residential Services		
Select the waiver funding source for the residential services the person is receiving	ID Waiver	LAH Waiver
Name of Service Provider	Address	
How long have you lived in your current residence?	Weeks/Months/Years	
Question:	Response:	HCBS Setting Requirement:
1.Did you choose where you live and receive services/supports?	☐ Yes ☐ No	*The setting was selected by the person from among setting options, including non-disability specific settings.*
2.Did you visit other places before choosing this one?	☐ Yes ☐ No	
3.Do you know how to relocate and request new housing?	☐ Yes ☐ No	
4.Do you own your home or have a lease?	☐ Yes ☐ No	*Specific unit or dwelling is owned, rented or occupied under a legally enforceable agreement.*
5.Do you know your rights as a tenant and protections from eviction?	☐ Yes ☐ No	
6.Can you close and lock your front door?	☐ Yes ☐ No	*Unit has lockable entrance door.*
Question:	Response:	HCBS Setting Requirement:
7.Do you have a key to your front door?	☐ Yes ☐ No	*Unit has lockable entrance door.*
8.Does anyone else have a key to your front door?	☐ Yes ☐ No	
9.Do others knock before entering your front door?	☐ Yes ☐ No	
10. Can you close and lock your bedroom door?	☐ Yes ☐ No	*Each person has privacy in their sleeping or living unit.*
11. Can you close and lock your bathroom door?	☐ Yes ☐ No	
12. Did you get to decide who has a key to your bedroom or bathroom?	☐ Yes ☐ No	
13. Do others knock before entering your bedroom?	☐ Yes ☐ No	
14. Were you given the option of a private room if you could afford it?	☐ Yes ☐ No	*Option for a private unit.*

15. Can you choose who you share your room with?	☐ Yes ☐ No	*Choice of roommates.*
16. Did you choose your roommate?	☐ Yes ☐ No	
17. Do you like living with your roommate?	☐ Yes ☐ No	
18. Do you know how to request a roommate change?	☐ Yes ☐ No	
19. Did you decorate your room?	☐ Yes ☐ No	*Freedom to furnish and decorate.*
20. Can you move the furniture where you want?	☐ Yes ☐ No	
21. Can you hang or put up pictures if you want to?	☐ Yes ☐ No	
22. Can you change the decorations in your room?	☐ Yes ☐ No	
23. Do you participate in activities like shopping, going to church or having lunch with family and friends?	☐ Yes ☐ No	*Integrated in and supports full access to the greater community.*
24. Do you know how to find out about upcoming events or activities that you might have an interest in?	☐ Yes ☐ No	
25. Do you have the help you need to participate in the activities you want to do?	☐ Yes ☐ No	
26. Are you able to get to the activities you would like to participate in?	☐ Yes ☐ No	
27. Do you make your own schedule?	☐ Yes ☐ No	*Freedom and support to control schedules and activities.*
28. Can you decide when you get up, take a bath, eat, exercise or participate in other activities?	☐ Yes ☐ No	
29. Can you watch television, listen to the radio and do things that you like when you want to?	☐ Yes ☐ No	
30. Can you eat when you want to?	☐ Yes ☐ No	*Access to food at any time.*
31. Can you eat where you want to?	☐ Yes ☐ No	
32. Can you eat what you want to?	☐ Yes ☐ No	
33. Can you request a different meal if you want one?	☐ Yes ☐ No	
34. Are snacks accessible and available anytime?	☐ Yes ☐ No	
Question:	Response:	HCBS Setting Requirement:
35. Can you have visitors?	☐ Yes ☐ No	*Allow visitors at any time.*
36. Can you have visitors at any time?	☐ Yes ☐ No	
37. Can you have private visits with family & friends if you want to?	☐ Yes ☐ No	
38. Do you have the supports you need to move around your room/house as you choose?	☐ Yes ☐ No	*Physically accessible.*
39. Can you enter and exit your room/house as you choose?	☐ Yes ☐ No	
40. Do you have full access to the common areas such as the kitchen, dining area, laundry, and shared living areas?	☐ Yes ☐ No	
41. Do you have a resident handbook or know how to get one? (if applicable)	☐ Yes ☐ No	*Policies outlining personal rights are available and accessible to the person.*
42. Do you understand the handbook or know who to ask if you have questions?	☐ Yes ☐ No	
43. Do you have access to a phone, computer or other technology?	☐ Yes ☐ No	

44. Do you have access to transportation to go the places you want to go?	☐ Yes ☐ No	*Optimizes personal initiative, autonomy, and independence in making life choices.*
45. Can you make decisions about your schedule, where you go, who you see, and when?	☐ Yes ☐ No	
Does the person participate in Personal Care Services? If yes, complete Section E; If no, SKIP Section E		(circle YES or NO)

Section E: Personal Care Services

Select the waiver funding source for Personal Care services the person is receiving	ID Waiver	LAH Waiver
Name of Service Provider	Address	

Question:	Response:	HCBS Setting Requirement:
1. Do you live with family in a family member's home?	☐ Yes ☐ No	*Choice in living arrangement.*
2. Do you live in your own home or apartment?	☐ Yes ☐ No	
3. Can you live in your own home or apartment if you want?	☐ Yes ☐ No	
4. Do you have the help you need to participate in the activities you want to do? *For example, are you able to get to the activities you want to participate in and the support you need to participate in those activities?*	☐ Yes ☐ No	*Integrated and supports access to the greater community.*
5. If you want to, can you go out in the community during the day? *For example, do you participate in activities like shopping, going to church or having lunch out with family and friends?* If Yes, how often?	☐ Every time I want to ☐ Most of the time I want to ☐ Not as much as I would like	*Integrated and supports access to the greater community.*

Question:	Response:	HCBS Setting Requirement:
6. Other than family or paid caregivers, do you spend time with people who do not have disabilities? If yes, how often?	☐ Every time I want to ☐ Most of the time I want to ☐ Not as much as I would like	*Integrated and supports access to the greater community.*
7. Do you know how to find out about upcoming events or activities in your community?	☐ Yes ☐ No	
8. If you want to, can you have a job or volunteer? *For example, do you have the support you need to look for a job or volunteer somewhere if you want?*	☐ Yes ☐ No	*Provides opportunities to seek employment or volunteer opportunities.*
9. Can you change how and where you receive personal care supports if you want to?	☐ Yes ☐ No	*The service facilitates personal choice regarding services and supports and who provides them.*
10. Can you be alone if you want/need to be while receiving personal care services? *For example, can you have a private conversation without others listening?*	☐ Yes ☐ No	*Ensures person's rights of privacy, dignity, respect and freedom from coercion and restraint.*
11. Do the staff who support you treat you the way you want to be treated? *For example, do staff listen and respond to your questions or concerns?*	☐ Yes ☐ No	
12. Do you have adequate privacy in your home?	☐ Yes ☐ No	

13. Can you close and lock your front door?	☐ Yes ☐ No	*Unit has lockable entrance door.*
14. Do you have a key to your home?	☐ Yes ☐ No	
15. Are you comfortable with the other people who have keys to your home?	☐ Yes ☐ No	
16. Do others knock before entering your bedroom?	☐ Yes ☐ No	*Each person has privacy in their sleeping or living unit.*
17. Can you close and lock your bedroom door?	☐ Yes ☐ No	
18. Can you close and lock your bathroom door?	☐ Yes ☐ No	
19. Are you comfortable with the other people who have a key to your bedroom or bathroom?	☐ Yes ☐ No	
Question:	Response:	HCBS Setting Requirement:
20. Can you eat when you want to?	☐ Yes ☐ No	*Access to food at any time.*
21. Can you eat where you want to?	☐ Yes ☐ No	
22. Can you eat what you want to?	☐ Yes ☐ No	
23. Are snacks accessible and available anytime?	☐ Yes ☐ No	
24. Do you have the supports you need to move around your room/house as you choose?	☐ Yes ☐ No	*Physical accessibility.*
25. Can you enter and exit your room/house as you choose?	☐ Yes ☐ No	
26. Do you have full access to the common areas such as the kitchen, dining area, laundry, and shared living areas?	☐ Yes ☐ No	
27. Do you have access to a phone, computer, or other technology?	☐ Yes ☐ No	*Optimizes personal initiative, autonomy, and independence in making life choices.*
28. Do you have access to transportation to go to places you want to go?	☐ Yes ☐ No	
29. Can you make decisions about your schedule, where you go, who you see, and when?	☐ Yes ☐ No	

Revisions to Person Centered Plan Required: ☐ Yes ☐ No *If yes, describe areas to be addressed:*

Remediation Plan Required: ☐ Yes ☐ No *If yes, describe areas to be addressed:*

Signature of Support Coordinator:	Date forwarded to Provider/Monitor:

Exhibit 5.1.

Application and Setting Review Form

Provider Name:

Date new application received: | **Provider Status:** ☐ New ☐ Existing

Part A To be completed by the Office of DD Certification – NOTE: Expanding providers complete 1-3; New providers complete 3

1. Is the agency currently on a Provisional Certification status?	☐ Yes ☐ No
2. Has the agency been on a Provisional Certification within the last two regular site visits?	☐ Yes ☐ No

If the answer to 1 or 2 is "YES", do not proceed with application! Return to OCA!
If the answer to 1 and 2 is "NO", return application to OCA. OCA will forward to Regional Community Services (RCS) Office.

3. Is the setting approved for a 6-month Temporary Operating Authority (TOA) following Life Safety Inspection?	☐ Yes ☐ No

Additional Comments:

Name of DDD Certification Staff: | **Date:**

Return to the Office of Certification Administration (OCA)

Part B To be completed by Regional Community Services (RCS) Office

1. Is the setting adjacent to or under the same roof as a building that houses a publicly or privately-operated setting which provides inpatient institutional care: skilled nursing setting (SNF), immediate care setting for individuals with intellectual disabilities (ICF/IID), institute for mental disease (IMD), or hospital?	☐ Yes ☐ No
2. Is the setting located on the grounds of, or immediately adjacent to, a building that is a public institution which provides inpatient institutional care (Skilled Nursing Setting (SNF), Intermediate Care Setting for Individuals with Intellectual Disabilities (ICF/IID), Institute for Mental Disease (IMD), or hospital?	☐ Yes ☐ No
3. Does the setting otherwise have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS and therefore, presumed institutional? a. If the answer is YES, what evidence is provided to overcome the presumption of an institutional setting?	☐ Yes ☐ No
4. Does the setting have more than 6 beds?	___ Yes ___ No
5. Would this proposed setting be located on the same street, court, etc., where these types of settings constitute more than 25% of all settings?	___ Yes ___ No
6. Is the setting adjacent (next to or shares a property line) to another setting?	___ Yes ___ No
IF EITHER ANSWER TO 4-6 IS YES, DO NOT PROCEED, SIGN FORM AND RETURN TO OFFICE OF CERTIFICATION ADMINISTRATION	
7. Is the setting physically accessible, and free from obstructions such as steps, lips in a doorway, narrow hallways, etc., or otherwise have any other safety concerns such as lighting, unsanitary conditions, exposed electrical wiring, area known for violent crimes, drug use, etc.?	☐ Yes ☐ No
8. Is the site recommended for Life Safety Inspection?	☐ Yes ☐ No

Additional Comments/Observations:

Name of person completing Assessment: | **Date:**

Return to the Office of Certification Administration (OCA)

Part C To be completed by the Office of Certification Administration

Sent to Life Safety: | **Date:**

Additional Comments:

OCA Director Signature | **Date:**

Exhibit 6.1

The following chart indicates how the Factors and Indicators are applied per organization based on the services provided:

Factors	Indicators	Services Provided by the Organization			Other Notes
		Case Mgt	Non-Congregate	Residential and/or Day	
Factor One	7	√ (6 indicators)	√	√	Indicator G not applicable to Case Management
Factor Two	5	√	√	√	
Factor Three	4	√	√	√	
Factor Four	6 (100% compliance)	√	√	√	
Factor Five	5 (100% compliance)	√ (4 indicators)	√	√	Indicator E not applicable for agencies not administering medications
Factor Six	4 (100% compliance)	√ (3 indicators)	√	√	Indicator D not applicable for Case Management
Factor Seven	4	√	√	√	
Factor Eight	9			√	
Factor Nine	4	√	√	√	
Factor Ten	3	√	√	√	Will be scored beginning October 2014
Factor Eleven	3	√	√	√	
Factor Twelve	3		√		
Factor Thirteen	7	√			
Number of Indicators Scored		**33 (36 beginning Oct. 2014)**	**30 (33 beginning Oct. 2014)**	**36 (39 beginning Oct. 2014)**	**For organizations providing services in more than one category, indicators are added as applicable**

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The following chart indicates how the Factors and Indicators are applied per organization based on the services provided:

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Factor Two	5	√	√	√	
Factor Three	4	√	√	√	
Factor Four	6 (100% compliance)	√	√	√	
Factor Five	5 (100% compliance)	√ (4 indicators)	√	√	Indicator E not applicable for agencies not administering medications
Factor Six	4 (100% compliance)	√ (3 indicators)	√	√	Indicator D not applicable for Case Management
Factor Seven	4	√	√	√	
Factor Eight	9			√	
Factor Nine	4	√	√	√	
Factor Ten	3	√	√	√	Will be scored beginning October 2014
Factor Eleven	3	√	√	√	
Factor Twelve	3		√		
Factor Thirteen	7	√			
Number of Indicators Scored		**33 (36 beginning Oct. 2014)**	**30 (33 beginning Oct. 2014)**	**36 (39 beginning Oct. 2014)**	**For organizations providing services in more than one category, indicators are added as applicable**